

11225

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

|   |                            |  |                                   |   |                        |  |                    |
|---|----------------------------|--|-----------------------------------|---|------------------------|--|--------------------|
| 1. PLACE OF DEATH:  |                            |  |                                   | 2. USUAL RESIDENCE (HOME) OF DECEASED:  |                        |  |                    |
| COUNTY <u>Talbot</u>  |                            | MARYLAND   |                                   | STATE <u>Maryland</u> COUNTY <u>Talbot</u>                                      |                        |  |                    |
| CITY (If outside corporate limits, write RURAL or and give nearest town) <u>40</u>  |                            | LENGTH OF STAY (in this place)   |                                   | CITY (If outside corporate limits, write RURAL and give nearest town) <u>40</u> |                        |  |                    |
| TOWN <u>Easton</u>  |                            |  |                                   | TOWN <u>Easton</u>  |                        |  |                    |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>80</u> <u>Memorial Hospital</u>  |                            |  |                                   | STREET ADDRESS (If rural give location) <u>1</u>                                |                        |  |                    |
| 3. NAME OF DECEASED: (First) (Middle) (Last)  |                            |  |                                   | 4. DATE (Month) (Day) (Year)  |                        |  |                    |
| DECEASED: (Type or Print) <u>Baby Boy Blackwell</u>   |                            |  |                                   | OF DEATH: <u>11</u> <u>14</u> <u>1955</u>                                       |                        |  |                    |
| 5. SEX: <u>m</u>  | 6. COLOR OR RACE: <u>B</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>single</u>  | 8. DATE OF BIRTH: <u>11-14-55</u> | 9. AGE last birthday yrs.   | IF UNDER 1 YEAR Months | IF UNDER 24 HRS. Days                      | Hours Min.         |
|   |                            |  |                                   |   |                        |  | <u>2</u> <u>10</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):  |                            | 10B. KIND OF BUSINESS OR INDUSTRY:   |                                   | 11. BIRTHPLACE (State or foreign country):                                      |                        | 12. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u> |                    |
| 13. FATHER'S NAME: <u>Richard Blackwell</u>   |                            |  |                                   | 14. MOTHER'S MAIDEN NAME: <u>Virginia Copper</u>                                |                        |  |                    |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)   |                            | 16. SOCIAL SECURITY NO.  |                                   | 17. INFORMANT & ADDRESS: <u>Richard Blackwell (father)</u>                      |                        |  |                    |
| 18. MEDICAL CERTIFICATION   |                            |  |                                   |   |                        |  |                    |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |                            |  |                                   |   |                        |  |                    |
| IMMEDIATE CAUSE <u>757.3</u>  |                            |  |                                   |   |                        |  |                    |
| ANTECEDENT CAUSE (S) <u>Hydrophoxia</u>   |                            |  |                                   |   |                        |  |                    |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO <u>Intestinal obstruction</u>   |                            |  |                                   |   |                        |  |                    |
| STATING UNDERLYING CAUSE LAST. <u>Obstruction of urethra</u>  |                            |  |                                   |   |                        |  |                    |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.  |                            |  |                                   |   |                        |  |                    |
| 19A. DATE OF OPERATION: <u>2</u>  |                            |  |                                   | 19B. MAJOR FINDINGS OF OPERATION  |                        |  |                    |
| 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                            |  |                                   |   |                        |  |                    |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                            | 21B. PLACE (Home, farm, factory, street, office bldg., etc.)   |                                   | 21C. WHERE DID (City or town) (County) (State)                                  |                        | INJURY OCCUR?                              |                    |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |                            | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |                                   | 21F. HOW DID INJURY OCCUR?  |                        |  |                    |
| 22. I hereby certify that I attended the deceased from ....., 19....., to ....., 19....., that I last saw the deceased alive on ....., 19....., and that death occurred at <u>3:50 AM</u> , from the causes and on the date stated above. |                            |  |                                   |   |                        |  |                    |
| SIGNATURE <u>Richard Blackwell</u>  |                            |  |                                   | ADDRESS <u>Easton Md</u>  |                        |  |                    |
| M.D. <u>18 Nov 1955</u>   |                            |  |                                   |   |                        |  |                    |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)  |                            | DATE THEREOF   |                                   | NAME OF CEMETERY OR CREMATORY   |                        | LOCATION (City, town, of county) (State)   |                    |
| <u>Burial</u>   |                            | <u>11/16/55</u>  |                                   | <u>Richards</u>   |                        | <u>Easton Md</u>                           |                    |
| DATE REC'D BY LOCAL REGISTRAR <u>11/15/55</u>   |                            | REGISTRAR'S SIGNATURE <u>N.W. Heeris</u>   |                                   | 24. FUNERAL DIRECTOR <u>James B. David</u>                                      |                        | ADDRESS                                    |                    |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

NOV 21 1955

RECEIVED

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11234

## 11226 CERTIFICATE OF DEATH

Item 7, Film G190 12-27-55 et

Reg. Dist. No. 290

|  |  |   |   |   |   |  |  |
|--|--|---|---|---|---|--|--|
| <b>1. PLACE OF DEATH</b>   |  |   |   | <b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>  |   |  |  |
| COUNTY <b>T a lbot</b>   |  | MARYLAND  |   | STATE <b>Maryland</b>   |   | COUNTY <b>Caroline</b>   |  |
| CITY (If outside corporate limits, write RURAL OR end give nearest town)<br><b>40 Easton</b>   |  | LENGTH OF STAY (in this place)<br><b>4 hrs 30 min</b>   |   | CITY (If outside corporate limits, write RURAL end give nearest town)<br>OR TOWN <b>Federalburg</b> |   | <b>05 X-2</b>  |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br><b>80 Memorial Hospital</b>   |  |   |   | STREET ADDRESS (If rural give location)   |   | ✓  |  |
| <b>3. NAME OF DECEASED</b> (First) (Middle) (Last)<br><b>Eddie Conway</b>  |  |   |   | <b>4. DATE OF DEATH</b> (Month) (Day) (Year)<br><b>November 21, 1955</b>                            |   |  |  |
| <b>5. SEX</b><br><b>M</b>  | <b>6. COLOR OR RACE</b><br><b>Col.</b> | <b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b><br><b>Widowed</b>                                     | <b>8. DATE OF BIRTH</b><br><b>9/15/1881</b> |   | <b>9. AGE last birthday</b><br><b>74</b> yrs. |  | <b>IF UNDER 1 YEAR</b><br>Months Days Hours Min. |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><b>Day Laborer</b>   |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b>  |   | <b>11. BIRTHPLACE</b> (State or foreign country)<br><b>Unknown Del.</b>                             |   | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><b>U.S.</b>                       |  |
| <b>13. FATHER'S NAME</b><br><b>Unknown</b>   |  |   |   | <b>14. MOTHER'S MAIDEN NAME</b><br><b>Unknown</b>   |   |  |  |
| <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)<br><b>372</b>   |  | <b>16. SOCIAL SECURITY NO.</b><br><b>222-03-8674</b>  |   | <b>17. INFORMANT &amp; ADDRESS</b><br><b>John Burnie (friend)</b>                                   |   |  |  |
| <b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>  |  |   |   | <b>18. MEDICAL CERTIFICATION</b>  |   |  |  |
| <b>420.1 IMMEDIATE CAUSE (A)</b><br><b>CHRONIC ARTERIO SCLEROSIS</b>   |  |   |   | <b>INTERVAL BETWEEN ONSET AND DEATH</b>   |   |  |  |
| <b>ANTECEDENT CAUSE(S) DUE TO (B)</b><br><b>cardiac failure</b>  |  |   |   |   |   |  |  |
| <b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)</b>   |  |   |   |   |   |  |  |
| <b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>  |  |   |   |   |   |  |  |
| <b>19a. DATE OF OPERATION</b>  |  | <b>19b. MAJOR FINDINGS OF OPERATION</b>   |   | <b>20. AUTOPSY</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |   |  |  |
| <b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>  |  | <b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>                                 |   | <b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)                                 |   |  |  |
| <b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)  |  | <b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |   | <b>21f. HOW DID INJURY OCCUR?</b>   |   |  |  |
| <b>22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at....., from the causes and on the date stated above.</b> |  |   |   |   |   |  |  |
| <b>SIGNATURE</b><br><b>Thurston Harrison</b>   |  | <b>M.D.</b>   |   | <b>ADDRESS</b> (Street, city, town, state)<br><b>Carlton Mayland</b>                                |   | <b>DATE SIGNED</b><br><b>22/Nov/55</b>                                   |  |
| <b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b><br><b>Burial</b>   |  | <b>DATE THEREOF</b><br><b>11-25-55</b>  |   | <b>NAME OF CEMETERY OR CREMATORY</b><br><b>Federal Hill</b>   |   | <b>LOCATION (City, town, or county) (State)</b><br><b>Federalburg Md</b> |  |
| <b>24. REC'D BY REGISTRAR</b><br><b>DATE</b> <b>11/23/55</b>   |  | <b>REGISTRAR'S SIGNATURE</b><br><b>N.H. Neerue</b>  |   | <b>25. FUNERAL DIRECTOR'S SIGNATURE</b><br><b>22 Hampton Don Federalburg Md</b>                     |   |  |  |

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NOV 30 1955

BUREAU V. S.

# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH-BALTIMORE 12

UNOFFICIAL

This is to certify that the within and foregoing is a true and correct copy of the original as the same appears in the files of the Department of Health of the Commonwealth of Massachusetts, and that the same has been duly filed for record in the office of the Registrar of Vital Statistics of the Commonwealth of Massachusetts, and that the same is a true and correct copy of the original as the same appears in the files of the Department of Health of the Commonwealth of Massachusetts, and that the same has been duly filed for record in the office of the Registrar of Vital Statistics of the Commonwealth of Massachusetts.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11236

11227

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

|  |                   |  |                     |   |                 |  |   |
|--|-------------------|--|---------------------|---|-----------------|--|---|
| 1. PLACE OF DEATH:   |                   |  |                     | 2. USUAL RESIDENCE (HOME) OF DECEASED:  |                 |  |   |
| COUNTY <b>Talbot</b>   |                   | MARYLAND   |                     | STATE <b>Md.</b>  |                 | COUNTY <b>Talbot</b>                     |   |
| CITY (If outside corporate limits, write RURAL or and give nearest town)   |                   | LENGTH OF STAY (in this place)   |                     | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN |                 |  |   |
| <b>40</b> TOWN <b>Easton</b>   |                   | <b>9 yrs</b>   |                     | <b>40</b> TOWN <b>Easton</b>  |                 |  |   |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS  |                   | Dover St.  |                     | STREET ADDRESS (If rural give location) <b>1</b> <b>Dover St.</b>             |                 |  |   |
| 3. NAME OF DECEASED: (First) (Middle) (Last)   |                   |  |                     | 4. DATE (Month) (Day) (Year) OF DEATH:  |                 |  |   |
| <b>Clara W. Dean</b>   |                   |  |                     | <b>Nov. 12 19 55</b>  |                 |  |   |
| 5. SEX:  | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):  | 8. DATE OF BIRTH:   | 9. AGE last birthday  | IF UNDER 1 YEAR | IF UNDER 24 HRS.                         |   |
| <b>F.</b>  | <b>White</b>      | <b>married</b>   | <b>Oct. 6, 1888</b> | <b>67 yrs.</b>  | Months          | Days                                     | Hours Min.  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):   |                   | 10B. KIND OF BUSINESS OR INDUSTRY:   |                     | 11. BIRTHPLACE (State or foreign country):                                    |                 | 12. CITIZEN OF WHAT COUNTRY?             |   |
| <b>housewife</b>   |                   |  |                     | <b>Caroline Co.</b>   |                 | <b>U.S.</b>                              |   |
| 13. FATHER'S NAME:   |                   |  |                     | 14. MOTHER'S MAIDEN NAME:   |                 |  |   |
| <b>Walter M. Wright</b>  |                   |  |                     | <b>Jennie Pritchett</b>   |                 |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)  |                   | 16. SOCIAL SECURITY NO.  |                     | 17. INFORMANT & ADDRESS:  |                 |  |   |
| <b>4</b>   |                   | <b>none</b>  |                     | <b>Elbert Dean Easton, Md.</b>  |                 |  |   |
| 18. MEDICAL CERTIFICATION  |                   |  |                     |   |                 |  | INTERVAL BETWEEN ONSET AND DEATH                                      |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |                   |  |                     |   |                 |  |   |
| <b>42011</b>   |                   |  |                     |   |                 |  |   |
| IMMEDIATE CAUSE (A)  |                   |  |                     |   |                 |  |   |
| <b>Capit and myocardium</b>  |                   |  |                     |   |                 |  |   |
| ANTECEDENT CAUSE (S)   |                   |  |                     |   |                 |  |   |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.  |                   |  |                     |   |                 |  |   |
| (B)  |                   |  |                     |   |                 |  |   |
| <b>myocardial infarction due</b>   |                   |  |                     |   |                 |  |   |
| (C)  |                   |  |                     |   |                 |  |   |
| <b>atherosclerotic coronary thrombosis</b>   |                   |  |                     |   |                 |  | <b>3 days</b>   |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.   |                   |  |                     |   |                 |  |   |
| 19A. DATE OF OPERATION:  |                   | 19B. MAJOR FINDINGS OF OPERATION   |                     |   |                 |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| <b>0</b>   |                   |  |                     |   |                 |  |   |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                   | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)   |                     | 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?                  |                 |  |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |                   | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |                     | 21F. HOW DID INJURY OCCUR?  |                 |  |   |
|  |                   |  |                     |   |                 |  |   |
| 22. I hereby certify that I attended the deceased from <b>10 hrs</b> , 19 <b>55</b> , to <b>12 hrs</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>12 hrs</b> , 19 <b>55</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above. |                   |  |                     |   |                 |  |   |
| SIGNATURE  |                   | M. D.  |                     | ADDRESS   |                 | DATE SIGNED                              |   |
| <b>Mem Tan Dean</b>  |                   | <b>M. D.</b>   |                     | <b>Carlton Dean Land</b>  |                 | <b>14 hrs 55'</b>                        |   |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)   |                   | DATE THEREOF   |                     | NAME OF CEMETERY OR CREMATORY   |                 | LOCATION (City, town, or county) (State) |   |
| <b>burial</b>  |                   | <b>Nov. 15, 1955</b>   |                     | <b>Spring Hill Cemetery</b>   |                 | <b>Easton, Talbot, Md.</b>               |   |
| DATE REC'D BY LOCAL REGISTRAR  |                   | REGISTRAR'S SIGNATURE  |                     | 24. FUNERAL DIRECTOR  |                 | ADDRESS                                  |   |
| <b>11-14-55</b>  |                   | <b>N. A. Newries</b>   |                     | <b>Maurice E. Newnam &amp; Son</b>  |                 | <b>Easton, Md.</b>                       |   |

BUREAU V. S.

NOV 17 1955

RECEIVED



11228 **CERTIFICATE OF DEATH**

11237

Reg. Dist. No. 290

|  |                                 |  |                                      |   |  |  |  |
|--|---------------------------------|--|--------------------------------------|---|--|--|--|
| <b>1. PLACE OF DEATH</b>   |                                 |  |                                      | <b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>  |  |  |  |
| COUNTY <u>Talbot</u>   |                                 | MARYLAND   |                                      | STATE <u>MD</u>   |  | COUNTY <u>Talbot</u>   |  |
| CITY (If outside corporate limits, write RURAL or and give nearest town)<br><u>40 Easton</u>   |                                 | LENGTH OF STAY (in this place)<br><u>Life</u>  |                                      | CITY (If outside corporate limits, write RURAL and give nearest town)<br><u>40 Easton</u> |  |  |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br><u>10 24 Throughgood Lane</u>   |                                 |  |                                      | STREET ADDRESS (If rural give location)<br><u>24 throughgood lane</u>                     |  |  |  |
| <b>3. NAME OF DECEASED</b><br>(Type or Print) <u>Charles Edward Dobson</u>   |                                 |  |                                      | <b>4. DATE OF DEATH</b><br>(Month) <u>11</u> (Day) <u>25</u> (Year) <u>1955</u>           |  |  |  |
| 5. SEX<br><u>Male</u>  | 6. COLOR OR RACE<br><u>Col.</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>  | 8. DATE OF BIRTH<br><u>11/7/1890</u> | 9. AGE last birthday<br><u>65</u> yrs.  | IF UNDER 1 YEAR<br>Months _____ Days _____ |  | IF UNDER 24 HRS.<br>Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Janitor</u>  |                                 | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Domestic</u>   |                                      | 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>                              |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>                            |  |
| 13. FATHER'S NAME<br><u>Charles E. Dobson</u>  |                                 |  |                                      | 14. MOTHER'S MAIDEN NAME<br><u>Mary E. Breeze</u>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unk.) <u>no</u>   |                                 | 16. SOCIAL SECURITY NO.<br><u>---</u>  |                                      | 17. INFORMANT & ADDRESS<br><u>Allen Breeze Easton, Md</u>                                 |  |  |  |
| <b>18. MEDICAL CERTIFICATION</b>   |                                 |  |                                      |   |  | <b>INTERVAL BETWEEN ONSET AND DEATH</b>                                  |  |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH<br><u>420.1 IMMEDIATE CAUSE (A) Coronary Occlusion</u>   |                                 |  |                                      |   |  | <u>Immediate</u>   |  |
| ANTECEDENT CAUSE(S) DUE TO<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.<br>(B) _____<br>(C) _____  |                                 |  |                                      |   |  |  |  |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.<br>_____  |                                 |  |                                      |   |  |  |  |
| 19a. DATE OF OPERATION<br><u>0</u>   |                                 | 19b. MAJOR FINDINGS OF OPERATION<br>_____  |                                      |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                 | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)                                 |                                      | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)                              |  |  |  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. _____   |                                 | 21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work |                                      | 21i. HOW DID INJURY OCCUR?<br>_____   |  |  |  |
| <b>22. I hereby certify that I attended the deceased from _____, 19 _____, to _____, 19 _____, that I last saw the deceased alive on _____, 19 _____, and that death occurred at _____ M., from the causes and on the date stated above.</b> |                                 |  |                                      |   |  |  |  |
| SIGNATURE<br><u>Louis M. Mitty DME</u>   |                                 | ADDRESS (Street, city, town, state)<br><u>Easton Md</u>  |                                      | DATE SIGNED<br><u>11/27/55</u>  |  |  |  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Burial</u>  |                                 | DATE THEREOF<br><u>11/28/55</u>  |                                      | NAME OF CEMETERY OR CREMATORY<br><u>Richards Cem</u>                                      |  | LOCATION (City, town, or county) (State)<br><u>Easton, Md.</u>           |  |
| 24. REC'D BY REGISTRAR<br>DATE <u>11/26/55</u>   |                                 | REGISTRAR'S SIGNATURE<br><u>N. H. Devine</u>   |                                      | 25. FUNERAL DIRECTOR'S SIGNATURE<br><u>James B. Eastwell</u>                              |  | ADDRESS<br><u>Easton, Md.</u>  |  |

## INSTRUCTIONS

**1** **TO ATTEND PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**2** **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

# 1958 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

1. NAME AND ADDRESS OF DECEASED

NAME OF DECEASED

2. PLACE OF DEATH

3. DATE OF DEATH

4. CAUSE OF DEATH

5. SEX

6. AGE

7. OCCUPATION

8. MARITAL STATUS

9. EDUCATION

10. RELIGION

11. RACE

12. BIRTH DATE

13. BIRTH PLACE

14. BIRTH ORDER

15. BIRTH SEX

16. BIRTH RACE

17. BIRTH RELIGION

18. BIRTH OCCUPATION

19. BIRTH MARITAL STATUS

20. BIRTH EDUCATION

21. BIRTH RELIGION

22. BIRTH OCCUPATION

23. BIRTH MARITAL STATUS

24. BIRTH EDUCATION

25. BIRTH RELIGION

26. BIRTH OCCUPATION

27. BIRTH MARITAL STATUS

28. BIRTH EDUCATION

29. BIRTH RELIGION

30. BIRTH OCCUPATION

31. BIRTH MARITAL STATUS

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171. BIRTH MARITAL STATUS

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278. BIRTH OCCUPATION

279. BIRTH MARITAL STATUS

280. BIRTH EDUCATION

281. BIRTH RELIGION

282. BIRTH OCCUPATION

283. BIRTH MARITAL STATUS

284. BIRTH EDUCATION



11229

## CERTIFICATE OF DEATH

Reg. Dist. No. 290...

|   |                                   |  |   |  |  |  |  |
|---|-----------------------------------|--|---|--|--|--|--|
| 1. PLACE OF DEATH:  |                                   |  |   | 2. USUAL RESIDENCE (HOME) OF DECEASED:   |  |  |  |
| COUNTY <b>Talbot</b>  |                                   | MARYLAND   |   | STATE <b>Md.</b>   |  | COUNTY <b>Talbot</b>   |  |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br>TOWN <b>Easton</b>   |                                   | LENGTH OF STAY<br>(in this place)  |   | CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR TOWN <b>Easton</b> |  |  |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br><b>505 Pleasant Place</b>  |                                   |  |   | STREET ADDRESS<br>(If rural give location)<br><b>505 Pleasant Place</b>                        |  |  |  |
| 3. NAME OF DECEASED:  |                                   |  |   | 4. DATE (Month) (Day) (Year) OF DEATH:   |  |  |  |
| (First) <b>Jane</b>   |                                   | (Middle) <b>Ellen</b>  |   | (Last) <b>Done</b>   |  | <b>Nov. 22 19 55</b>   |  |
| 5. SEX:<br><b>Female</b>  | 6. COLOR OR RACE:<br><b>white</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>married</b>   | 8. DATE OF BIRTH:<br><b>Oct. 13, 1877</b> |  | 9. AGE last birthday<br><b>78</b> yrs. | IF UNDER 1 YEAR<br>Months Days Hours Min.                                |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>housewife</b>   |                                   | 10B. KIND OF BUSINESS OR INDUSTRY:   |   | 11. BIRTHPLACE (State or foreign country): <b>Blackburn, England</b>                           |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>                             |  |
| 13. FATHER'S NAME:<br><b>Wm. P. Butler</b>  |                                   |  |   | 14. MOTHER'S MAIDEN NAME:<br><b>Elizabeth Sharples</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)  |                                   | 16. SOCIAL SECURITY NO.  |   | 17. INFORMANT & ADDRESS:<br><b>Mr. Harry Done Easton, Md.</b>                                  |  |  |  |
| 18. MEDICAL CERTIFICATION   |                                   |  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH   |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |                                   |  |   |  |  |  |  |
| IMMEDIATE CAUSE (A) <b>331X Cerebral Hemangioma</b>   |                                   |  |   |  |  |  | <b>pendulum</b>  |
| ANTECEDENT CAUSE (B) DUE TO   |                                   |  |   |  |  |  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.   |                                   |  |   |  |  |  |  |
| (C) DUE TO  |                                   |  |   |  |  |  |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.  |                                   |  |   |  |  |  |  |
| 19A. DATE OF OPERATION:   |                                   | 19B. MAJOR FINDINGS OF OPERATION   |   |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                   | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.  |   | 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?                                   |  |  |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |                                   | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |   | 21F. HOW DID INJURY OCCUR?   |  |  |  |
| 22. I hereby certify that I attended the deceased from ..... , 19....., to ..... , 19....., that I last saw the deceased alive on ..... , 19....., and that death occurred at <b>3 A</b> M, from the causes and on the date stated above. |                                   |  |   |  |  |  |  |
| SIGNATURE<br><b>Thurston Harrison</b>   |                                   | ADDRESS<br><b>Easton Maryland</b>  |   | DATE SIGNED<br><b>25 Nov 55</b>  |  |  |  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>cremation</b>  |                                   | DATE THEREOF<br><b>11-26-55</b>  |   | NAME OF CEMETERY OR CREMATORY<br><b>Silverbrook Crematory</b>                                  |  | LOCATION (City, town, or county) (State)<br><b>Silverbrook, Delaware</b> |  |
| DATE REC'D BY LOCAL REGISTRAR<br><b>11/23/55</b>  |                                   | REGISTRAR'S SIGNATURE<br><b>N.H. Newnam</b>  |   | 24. FUNERAL DIRECTOR<br><b>Maurice E. Newnam &amp; Son</b>                                     |  | ADDRESS<br><b>Easton, Md.</b>  |  |

MARGIN RESERVED FOR BINDING

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 6 1955

BUREAU V. 3

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11240

11230

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

|   |  |  |                                      |  |                 |   |                  |
|---|--|--|--------------------------------------|--|-----------------|---|------------------|
| 1. PLACE OF DEATH   |  |  |                                      | 2. USUAL RESIDENCE (HOME) OF DECEASED  |                 |   |                  |
| COUNTY <u>Talbot</u>  |  | STATE <u>Md</u>  |                                      | COUNTY <u>Caroline</u>   |                 |   |                  |
| CITY (If outside corporate limits, write RURAL and give nearest town)   |  | LENGTH OF STAY (in this place)   |                                      | CITY (If outside corporate limits, write RURAL and give nearest town)            |                 |   |                  |
| TOWN <u>Easton</u>  |  | <u>10 days</u>   |                                      | TOWN <u>Denton</u>   |                 | <u>05X-2</u>                            |                  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hosp</u>  |  |  |                                      | STREET ADDRESS (If rural give location) <u>✓</u>                                 |                 |   |                  |
| 3. NAME OF DECEASED (Type or Print)   |  |  |                                      | 4. DATE OF DEATH   |                 |   |                  |
| (First) <u>Naomi</u> (Middle) <u>B.</u> (Last) <u>Dyott</u>   |  |  |                                      | (Month) <u>November</u> (Day) <u>20</u> (Year) <u>1955</u>                       |                 |   |                  |
| 5. SEX <u>F</u>   | 6. COLOR OR RACE <u>W</u>                | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)   | 8. DATE OF BIRTH <u>July 25 1900</u> | 9. AGE last birthday <u>55</u> yrs.  | IF UNDER 1 YEAR |   | IF UNDER 24 HRS. |
|   |  |  |                                      |  | Months          | Days                                    | Hours Min.       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>HW</u>  |                                      | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u>                        |                 | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |                  |
| 13. FATHER'S NAME <u>John Foster</u>  |  |  |                                      | 14. MOTHER'S MAIDEN NAME <u>Margaret Ball</u>                                    |                 |   |                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)   |  | 16. SOCIAL SECURITY NO.  |                                      | 17. INFORMANT & ADDRESS <u>Mrs Mary Prades (Daughter)</u>                        |                 |   |                  |
|   |  | (If Yes, give war or dates of service)   |                                      |  |                 |   |                  |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |  |  |                                      | 18. MEDICAL CERTIFICATION  |                 |   |                  |
| 414X IMMEDIATE CAUSE (A) <u>Cardiac spasm</u>   |  |  |                                      | INTERVAL BETWEEN ONSET AND DEATH <u>3 wks.</u>                                   |                 |   |                  |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic rheumatic endocarditis</u>  |  |  |                                      | (C) <u>✓</u>   |                 |   |                  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C)   |  |  |                                      |  |                 |   |                  |
| 11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.   |  |  |                                      |  |                 |   |                  |
| 19a. DATE OF OPERATION  |  | 19b. MAJOR FINDINGS OF OPERATION   |                                      | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                 |   |                  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)                                 |                                      | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)                     |                 |   |                  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour)   |  | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |                                      | 21f. HOW DID INJURY OCCUR?   |                 |   |                  |
|   |  | M.   |                                      |  |                 |   |                  |
| 22. I hereby certify that I attended the deceased from <u>10 AM</u> , 19 <u>55</u> , to <u>20 Nov, 19 55</u> , that I last saw the deceased alive on <u>20 Nov</u> , 19 <u>55</u> , and that death occurred at <u>7:30 P</u> M, from the causes and on the date stated above. |  |  |                                      |  |                 |   |                  |
| SIGNATURE <u>Monte A. ...</u> M.D.  |  |  |                                      | ADDRESS (Street, city, town, state) <u>Easton, Md.</u>                           |                 | DATE SIGNED <u>25 Nov 55</u>            |                  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>  | DATE THEREOF <u>Nov. 23, 1955</u>        | NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>   |                                      | LOCATION (City, town, or county) <u>Easton, Md.</u>                              |                 | (State)                                 |                  |
| 24. REC'D BY REGISTRAR <u>11-21-55</u>  | REGISTRAR'S SIGNATURE <u>H.A. Neerue</u> | 25. FUNERAL DIRECTOR'S SIGNATURE <u>J. V. ...</u>  |                                      | ADDRESS <u>Denton, Md.</u>   |                 |   |                  |

BUREAU V. S.

DEC 6 1955

RECEIVED

## 11231 CERTIFICATE OF DEATH

Reg. Dist. No. 290...

|  |                                   |  |  |   |                                |  |  |
|--|-----------------------------------|--|--|---|--------------------------------|--|--|
| 1. PLACE OF DEATH:   |                                   |  |  | 2. USUAL RESIDENCE (HOME) OF DECEASED:  |                                |  |  |
| COUNTY <b>Talbot</b>   |                                   | MARYLAND   |  | STATE <b>Md.</b>  |                                | COUNTY <b>Talbot</b>   |  |
| CITY (If outside corporate limits, write RURAL OR and give nearest town)<br><b>40</b> <b>Easton</b>  |                                   | LENGTH OF STAY (in this place)<br><b>10 yrs</b>  |  | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>40</b> <b>Easton</b> |                                |  |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>00</b> <b>206 South St.</b>   |                                   |  |  | STREET ADDRESS (If rural give location)<br><b>206 South St.</b>                                       |                                |  |  |
| 3. NAME OF DECEASED: (First) (Middle) (Last)<br><b>Lemuel Fleetwood</b>  |                                   |  |  | 4. DATE (Month) (Day) (Year) OF DEATH:<br><b>Nov. 28, 1955</b>  |                                |  |  |
| 5. SEX:<br><b>Male</b>   | 6. COLOR OR RACE:<br><b>white</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):<br><b>widower</b>  | 8. DATE OF BIRTH:<br><b>Nov. 9, 1870</b> | 9. AGE last birthday<br><b>85 yrs.</b>  | IF UNDER 1 YEAR<br>Months Days | IF UNDER 24 HRS.<br>Hours Min.   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):<br><b>farm labor</b>  |                                   |  | 10B. KIND OF BUSINESS OR INDUSTRY:       | 11. BIRTHPLACE (State or foreign country):<br><b>Md.</b>  |                                | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>                             |  |
| 13. FATHER'S NAME:<br><b>unknown</b>   |                                   |  |  | 14. MOTHER'S MAIDEN NAME:<br><b>unknown</b>   |                                |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)  |                                   | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT & ADDRESS:<br><b>Mrs. Pernie Dyott Easton, Md.</b>                                      |                                |  |  |
| 18. MEDICAL CERTIFICATION  |                                   |  |  |   |                                | INTERVAL BETWEEN ONSET AND DEATH   |  |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |                                   |  |  |   |                                |  |  |
| IMMEDIATE CAUSE<br><b>420.1</b>  |                                   |  |  |   |                                |  |  |
| ANTECEDENT CAUSE (S)   |                                   |  |  |   |                                |  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.  |                                   |  |  |   |                                |  |  |
| (A) <b>Coronary Thrombosis</b>   |                                   |  |  |   |                                | <b>less</b>  |  |
| (B) <b>Coronary Sclerosis</b>  |                                   |  |  |   |                                | <b>yes</b>   |  |
| (C) <b>Pneumonia</b>   |                                   |  |  |   |                                | <b>yes</b>   |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.   |                                   |  |  |   |                                |  |  |
| 19A. DATE OF OPERATION:<br><b>0</b>  |                                   |  |  | 19B. MAJOR FINDINGS OF OPERATION  |                                | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                   | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)   |  | 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?  |                                |  |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |                                   | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |                                |  |  |
| 22. I hereby certify that I attended the deceased from <b>Sept 1, 1955</b> , to <b>Nov 28, 1955</b> , that I last saw the deceased alive on <b>Nov 27, 1955</b> , and that death occurred at <b>11 A. M.</b> from the causes and on the date stated above. |                                   |  |  |   |                                |  |  |
| SIGNATURE<br><b>W. J. Buell</b>  |                                   |  |  | ADDRESS<br><b>M. D. Easton</b>  |                                | DATE SIGNED<br><b>11/30/55</b>   |  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>burial</b>  |                                   | DATE THEREOF<br><b>11-30-55</b>  |  | NAME OF CEMETERY OR CREMATORY<br><b>Spring Hill Cemetery</b>  |                                | LOCATION (City, town, or county) (State)<br><b>Easton, Talbot, Md.</b>   |  |
| DATE REC'D BY LOCAL REGISTRAR<br><b>11/29/55</b>   |                                   | REGISTRAR'S SIGNATURE<br><b>N. A. Newnam</b>   |  | 24. FUNERAL DIRECTOR ADDRESS<br><b>Maurice E. Newnam &amp; Son Easton, Md.</b>                        |                                |  |  |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 6 1955

BUREAU V. 2



## INSTRUCTIONS

**1**  
**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filled with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11252 CERTIFICATE OF DEATH

11242

Reg. Dist. No. 290

|  |                                     |  |  |  |                                       |  |                                       |
|--|-------------------------------------|--|--|--|---------------------------------------|--|---------------------------------------|
| <b>1. PLACE OF DEATH</b>   |                                     |  |  | <b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>   |                                       |  |                                       |
| COUNTY <u>Talbot</u>   |                                     | MARYLAND   |  | STATE <u>MD.</u>   |                                       | COUNTY <u>Talbot</u>   |                                       |
| CITY (If outside corporate limits, write RURAL OR end give nearest town)<br>TOWN <u>Easton (rural)</u>   |                                     | LENGTH OF STAY (In this place)<br><u>40 yrs.</u>   |  | CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR TOWN <u>Easton (Rural)</u> |                                       | X  |                                       |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br><u>00 Easton (rural)</u>  |                                     |  |  | STREET ADDRESS (If rural give location)<br><u>Easton (Rural)</u>                                       |                                       |  |                                       |
| <b>3. NAME OF DECEASED</b> (First) (Middle) (Last)<br>(Type or Print) <u>BARRY</u> <u>THEO</u> <u>FOX</u>  |                                     |  |  | <b>4. DATE OF DEATH</b> (Month) (Day) (Year)<br><u>Nov.</u> <u>9</u> <u>1955</u>                       |                                       |  |                                       |
| <b>5. SEX</b><br><u>M</u>  | <b>6. COLOR OR RACE</b><br><u>W</u> | <b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b><br><u>married</u>  | <b>8. DATE OF BIRTH</b><br><u>MAY 17, 1883</u> | <b>9. AGE last birthday</b><br><u>72</u> yrs.  | <b>IF UNDER 1 YEAR</b><br>Months Days |  | <b>IF UNDER 24 HRS.</b><br>Hours Min. |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>preacher of Brethren Church</u>   |                                     | <b>10b. KIND OF BUSINESS OR INDUSTRY</b>   |  | <b>11. BIRTHPLACE</b> (State or foreign country)<br><u>Pennsylvania</u>                                |                                       | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>U.S.</u>   |                                       |
| <b>13. FATHER'S NAME</b><br><u>Jacob Fox</u>   |                                     |  |  | <b>14. MOTHER'S MAIDEN NAME</b><br><u>Lilly Speck</u>  |                                       |  |                                       |
| <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b><br>(Yes, no, or unk.) <u>9</u> (If Yes, give war or dates of service)  |                                     | <b>16. SOCIAL SECURITY NO.</b><br><u>214 - 32 - 7490</u>   |  | <b>17. INFORMANT &amp; ADDRESS</b><br><u>Mrs. Minnie Fox Easton, Md.</u>                               |                                       |  |                                       |
| <b>18. MEDICAL CERTIFICATION</b>   |                                     |  |  |  |                                       | <b>INTERVAL BETWEEN ONSET AND DEATH</b>  |                                       |
| <b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b><br><u>194X</u><br>IMMEDIATE CAUSE (A) <u>CARCINOMA OF THYROID</u>  |                                     |  |  |  |                                       | <u>6 mos.</u>  |                                       |
| ANTECEDENT CAUSE(S) DUE TO (B) _____   |                                     |  |  |  |                                       |  |                                       |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) _____  |                                     |  |  |  |                                       |  |                                       |
| <b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>  |                                     |  |  |  |                                       |  |                                       |
| <b>19a. DATE OF OPERATION</b><br><u>1 6-24-55</u>  |                                     | <b>19b. MAJOR FINDINGS OF OPERATION</b><br><u>CARCINOMA OF THYROID</u>   |  |  |                                       | <b>20. AUTOPSY?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                       |
| <b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b><br><input type="checkbox"/>  |                                     | <b>21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)</b>  |  | <b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)                                    |                                       |  |                                       |
| <b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)   |                                     | <b>21e. INJURY OCCURRED</b><br>White <input type="checkbox"/> Not white <input type="checkbox"/><br>M. at work <input type="checkbox"/> at work <input type="checkbox"/> |  | <b>21f. HOW DID INJURY OCCUR?</b>  |                                       |  |                                       |
| <b>22. I hereby certify</b> that I attended the deceased from <u>JULY</u> , 19 <u>54</u> , to <u>NOV. 9</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>NOV. 9</u> , 19 <u>55</u> , and that death occurred at <u>8:45 P.</u> M, from the causes and on the date stated above. |                                     |  |  |  |                                       |  |                                       |
| <b>SIGNATURE</b><br><u>Donald A. Bartley</u>   |                                     |  |  | <b>ADDRESS</b> (Street, city, town, state)<br><u>977 Hanson St. Easton, Md.</u>                        |                                       | <b>DATE SIGNED</b><br><u>11-9-55</u>   |                                       |
| <b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b><br><u>burial</u>   |                                     | <b>DATE THEREOF</b><br><u>11-12-55</u>   |  | <b>NAME OF CEMETERY OR CREMATORY</b><br><u>Fairview Cemetery</u>                                       |                                       | <b>LOCATION</b> (City, town, or county) (State)<br><u>Cordova, Talbot, Maryland</u>        |                                       |
| <b>24. REC'D BY REGISTRAR</b><br>DATE <u>11/11/55</u>  |                                     | <b>REGISTRAR'S SIGNATURE</b><br><u>Neta H. Morris</u>  |  | <b>25. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>Maurice E. Newman &amp; Son</u>                          |                                       |  |                                       |
|  |                                     |  |  | <b>ADDRESS</b><br><u>Easton, Md.</u>   |                                       |  |                                       |

# CERTIFICATE OF DEATH

Reg. Dist. No. 31

LOCAL HEALTH OFFICER'S SIGNATURE

DATE OF DEATH

MARRIAGE

DECEASED

IN MEDICAL DEPT. SECTION

1. NAME OF DECEASED  
2. SEX  
3. AGE  
4. OCCUPATION  
5. PLACE OF BIRTH  
6. DATE OF BIRTH  
7. PLACE OF DEATH  
8. CAUSE OF DEATH  
9. MANNER OF DEATH  
10. SIGNATURE OF DECEASED  
11. SIGNATURE OF WITNESSES  
12. SIGNATURE OF MEDICAL DEPT. SECTION

BUREAU V. S.

NOV 17 1955

RECEIVED

INSTRUCTIONS

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**2** **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11253 CERTIFICATE OF DEATH

11243

Reg. Dist. No. 291

|   |   |   |  |  |   |  |  |
|---|---|---|--|--|---|--|--|
| <b>1. PLACE OF DEATH</b>  |   |   |  | <b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>   |   |  |  |
| COUNTY <u>Talbot</u>  |   | MARYLAND  |  | STATE <u>Maryland</u>  |   | COUNTY <u>Talbot</u>   |  |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br>TOWN <u>Royal Oak</u>  |   | LENGTH OF STAY (in this place)<br><u>50 yrs.</u>  |  | CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR TOWN           |   |  |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS   |   |   |  | STREET ADDRESS (If rural give location)  |   |  |  |
| <b>3. NAME OF DECEASED</b> (Type or Print)  |   |   |  | <b>4. DATE OF DEATH</b>  |   |  |  |
| (First) <u>Annie</u>  |   | (Middle) <u>V.</u>  |  | (Last) <u>Frampton.</u>  |   | (Month) (Day) (Year)<br><u>Nov. 9, 1955</u>                                    |  |
| <b>5. SEX</b><br><u>F.</u>  | <b>6. COLOR OR RACE</b><br><u>White</u> | <b>7. SINGLE, MARRIED, WIDOWED, DIVORCED</b> (Specify)<br><u>Widowed</u>                                      | <b>8. DATE OF BIRTH</b><br><u>1867</u> |  | <b>9. AGE last birthday</b><br><u>88</u> yrs. | <b>IF UNDER 1 YEAR</b><br>Months Days<br><b>IF UNDER 24 HRS.</b><br>Hours Min. |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>housekeeper</u>  |   | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><u>own home</u>   |  | <b>11. BIRTHPLACE</b> (State or foreign country)<br><u>Talbot County</u>                   |   | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>U. S.</u>                            |  |
| <b>13. FATHER'S NAME</b><br><u>Nicholas Leonard.</u>  |   |   |  | <b>14. MOTHER'S MAIDEN NAME</b><br><u>Mary Ellen Frampton</u>                              |   |  |  |
| <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)<br><u>No</u>   |   | <b>16. SOCIAL SECURITY NO.</b> (If Yes, give year or dates of service)  |  | <b>17. INFORMANT &amp; ADDRESS</b><br><u>James Fergusson, Royal Oak.</u>                   |   |  |  |
| <b>18. MEDICAL CERTIFICATION</b>  |   |   |  | <b>INTERVAL BETWEEN ONSET AND DEATH</b>  |   |  |  |
| <b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>  |   |   |  |  |   |  |  |
| IMMEDIATE CAUSE (A) <u>Cerebral apoplexy</u>  |   |   |  |  |   |  |  |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension</u>  |   |   |  |  |   |  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C)   |   |   |  |  |   |  |  |
| <b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>  |   |   |  |  |   |  |  |
| <b>19a. DATE OF OPERATION</b><br><u>0-</u>  |   | <b>19b. MAJOR FINDINGS OF OPERATION</b>   |  | <b>20. AUTOPSY?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |  |
| <b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | <b>21b. PLACE</b> (Home, farm, factory, OF INJURY street, office bldg., etc.)                                 |  | <b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)                        |   |  |  |
| <b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)  |   | <b>21a. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | <b>21i. HOW DID INJURY OCCUR?</b>  |   |  |  |
| <b>22. I hereby certify</b> that I attended the deceased from <u>22 Oct.</u> , 19 <u>55</u> , to <u>9 Nov.</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>8 Nov.</u> , 19 <u>55</u> , and that death occurred at <u>10 a.m.</u> , 19 <u>55</u> , from the causes and on the date stated above. |   |   |  |  |   |  |  |
| <b>SIGNATURE</b><br><u>Robt Perkins</u>   |   |   |  | <b>ADDRESS</b> (Street, city, town, state)<br><u>Royal Oak Md.</u>                         |   | <b>DATE SIGNED</b><br><u>md.</u>   |  |
| <b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b><br><u>Burial</u>  |   | <b>DATE THEREOF</b><br><u>November 11, 1955.</u>  |  | <b>NAME OF CEMETERY OR CREMATORY</b><br><u>Spring Hill</u>                                 |   | <b>LOCATION</b> (City, town, or county) (State)<br><u>Easton, Md.</u>          |  |
| <b>24. REC'D BY REGISTRAR</b><br>DATE <u>11-14-55</u>   |   | <b>REGISTRAR'S SIGNATURE</b><br><u>Mrs. Robt R. Smith</u>   |  | <b>25. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>Robert</u>                                   |   | <b>ADDRESS</b><br><u>Easton</u>  |  |

CERTIFICATE OF DEATH

Form No. 100-101

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

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MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

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MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

RECEIVED  
NOV 16 1955  
BUREAU V. 3

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11244

11232

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

|  |                   |  |                   |   |                 |  |            |
|--|-------------------|--|-------------------|---|-----------------|--|------------|
| 1. PLACE OF DEATH:   |                   |  |                   | 2. USUAL RESIDENCE (HOME) OF DECEASED:                                |                 |  |            |
| COUNTY <u>Talbot</u>   |                   | MARYLAND   |                   | STATE <u>Maryland</u> COUNTY <u>Talbot</u>                            |                 |  |            |
| CITY (If outside corporate limits, write RURAL OR and give nearest town)   |                   | LENGTH OF STAY (in this place)   |                   | CITY (If outside corporate limits, write RURAL and give nearest town) |                 |  |            |
| 40 TOWN <u>Easton</u>  |                   | 1 da. 1 hr 55 min  |                   | 40 TOWN <u>Easton</u>   |                 |  |            |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS  |                   |  |                   | STREET ADDRESS (If rural give location)                               |                 |  |            |
| 80 <u>Memorial Hospital</u>  |                   |  |                   | 129 N. Washington Street  |                 |  |            |
| 3. NAME OF DECEASED: (First) (Middle) (Last)   |                   |  |                   | 4. DATE (Month) (Day) (Year) OF DEATH:                                |                 |  |            |
| Florence H. Frampton   |                   |  |                   | 11 16 1955  |                 |  |            |
| 5. SEX:  | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):  | 8. DATE OF BIRTH: | 9. AGE last birthday  | IF UNDER 1 YEAR | IF UNDER 24 HRS.   |            |
| Female   | W                 | Married  | Jan. 12, 1869     | 86 yrs.   | Months          | Days   | Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):   |                   | 10B. KIND OF BUSINESS OR INDUSTRY:   |                   | 11. BIRTHPLACE (State or foreign country):                            |                 | 12. CITIZEN OF WHAT COUNTRY?   |            |
| H.W.   |                   |  |                   | Maryland  |                 | U.S.A.   |            |
| 13. FATHER'S NAME:   |                   |  |                   | 14. MOTHER'S MAIDEN NAME:   |                 |  |            |
| Nathan T. Hubbard  |                   |  |                   | Georgia Etta Flowers  |                 |  |            |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)  |                   | 16. SOCIAL SECURITY NO.  |                   | 17. INFORMANT & ADDRESS:  |                 |  |            |
| 9  |                   |  |                   | Mr. Albert E. Frampton (husband)                                      |                 |  |            |
| 18. MEDICAL CERTIFICATION  |                   |  |                   |   |                 |  |            |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |                   |  |                   |   |                 |  |            |
| 296X IMMEDIATE CAUSE (A) <u>Intestinal hemorrhage</u>  |                   |  |                   |   |                 |  |            |
| ANTECEDENT CAUSE (S) (B) <u>Hemorrhagic diathesis</u>  |                   |  |                   |   |                 |  |            |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Port.</u>   |                   |  |                   |   |                 |  |            |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.   |                   |  |                   |   |                 |  |            |
| 19A. DATE OF OPERATION:  |                   | 19B. MAJOR FINDINGS OF OPERATION   |                   |   |                 | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |            |
| 314 Nov. 1955  |                   | Dissection of clump; irregularly shaped  |                   |   |                 |  |            |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                   | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)   |                   | 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?          |                 |  |            |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |                   | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |                   | 21F. HOW DID INJURY OCCUR?  |                 |  |            |
|  |                   | M.   |                   |   |                 |  |            |
| 22. I hereby certify that I attended the deceased from ..... , 19....., to ..... , 19....., that I last saw the deceased alive on ..... , 19....., and that death occurred at 1:25 A.M., from the causes and on the date stated above. |                   |  |                   |   |                 |  |            |
| SIGNATURE  |                   | M.D.   |                   | ADDRESS   |                 | DATE SIGNED  |            |
| <u>Ed. Schmidt</u>   |                   | <u>Coxton</u>  |                   | <u>Coxton</u>   |                 | 18 Nov 1955  |            |
| 23. BURIAL CREMATION, REMOVAL (SPECIFY)  |                   | DATE THEREOF   |                   | NAME OF CEMETERY OR CREMATORY   |                 | LOCATION (City, town, or county) (State)   |            |
| <u>18-18-55</u>  |                   | <u>Spring Hill</u>   |                   | <u>Coxton</u>   |                 | <u>Cal</u>   |            |
| DATE REC'D BY LOCAL REGISTRAR  |                   | REGISTRAR'S SIGNATURE  |                   | 24. FUNERAL DIRECTOR  |                 | ADDRESS  |            |
| 11/17/55   |                   | <u>N.H. Nerio</u>  |                   | <u>Cal</u>  |                 | <u>Cal</u>   |            |

RECEIVED

NOV 21 1955

BUREAU V. S.



1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11245

## 11233 CERTIFICATE OF DEATH

Reg. Dist. No. 290

|  |                                |   |   |
|--|--------------------------------|---|---|
| <b>1. PLACE OF DEATH</b>   |                                | <b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>  |   |
| COUNTY <u>Talbot</u>   | MARYLAND                       | STATE <u>Maryland</u> COUNTY <u>Queen Anne</u>  |   |
| CITY (If outside corporate limits, write RURAL OR and give nearest town)   | LENGTH OF STAY (In this place) | CITY (If outside corporate limits, write RURAL and give nearest town)   |   |
| TOWN <u>40 Easton</u>  | <u>4 wks</u>                   | TOWN <u>Grasonville</u> <u>17x-2</u>  |   |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS  |                                | STREET ADDRESS (If rural give location)   |   |
| <u>80 Memorial Hospital</u>  |                                | <u>✓</u>  |   |
| <b>3. NAME OF DECEASED</b> (Type or Print)   |                                | <b>4. DATE OF DEATH</b> (Month) (Day) (Year)  |   |
| <u>Donald</u> (First) <u>Gould</u> (Middle) (Last)   |                                | <u>Nov. 25</u> 19 <u>55</u>   |   |
| <b>5. SEX</b>  | <b>6. COLOR OR RACE</b>        | <b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>   | <b>8. DATE OF BIRTH</b>                         |
| <u>M</u>   | <u>col</u>                     |   | <u>May, 1955</u>                                |
| <b>9. AGE last birthday</b>  |                                | <b>10. CITIZEN OF WHAT COUNTRY?</b>   |   |
| <u>5 mo</u> yrs. <u>6</u> Months   |                                | <u>USA</u>  |   |
| <b>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b>   |                                | <b>10b. KIND OF BUSINESS OR INDUSTRY</b>  |   |
|  |                                | <u>MARYLAND</u>   |   |
| <b>11. FATHER'S NAME</b>   |                                | <b>12. MOTHER'S MAIDEN NAME</b>   |   |
| <u>George Gould</u>  |                                | <u>Beulah M. Brown</u>  |   |
| <b>13. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)</b> (If Yes, give war or dates of service)  |                                | <b>14. SOCIAL SECURITY NO.</b>  |   |
| <u>9</u>   |                                |   |   |
| <b>15. INFORMANT &amp; ADDRESS</b>   |                                |   |   |
| <u>George Gould (father)</u>   |                                |   |   |
| <b>16. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>  |                                | <b>17. MEDICAL CERTIFICATION</b>  |   |
| <u>493x</u> IMMEDIATE CAUSE (A) <u>Cholerae typhoides left ventricle</u>   |                                | INTERVAL BETWEEN ONSET AND DEATH  |   |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Klebsiella pneumoniae</u>  |                                |   |   |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)   |                                |   |   |
| <b>18. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>   |                                |   |   |
| <b>19a. DATE OF OPERATION</b>  |                                | <b>19b. MAJOR FINDINGS OF OPERATION</b>   |   |
| <u>22</u>  |                                |   |   |
| <b>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>  |                                | <b>20b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>                                 |   |
|  |                                |   |   |
| <b>21a. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>   |                                | <b>21b. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work</b> |   |
|  |                                |   |   |
| <b>22. I hereby certify that I attended the deceased from <u>10/29</u> 19<u>55</u>, to <u>11/25</u> 19<u>55</u>, that I last saw the deceased alive on <u>11/25</u> 19<u>55</u>, and that death occurred at <u>8:24</u> M, from the causes and on the date stated above.</b> |                                | <b>23. HOW DID INJURY OCCUR?</b>  |   |
| <b>SIGNATURE</b> <u>John H. Neeris</u>   |                                | <b>DATE SIGNED</b> <u>78/00/1955</u>  |   |
| <b>ADDRESS (Street, city, town, state)</b> <u>Coxton</u>   |                                | <b>DATE SIGNED</b> <u>78/00/1955</u>  |   |
| <b>M. D.</b>   |                                | <b>DATE SIGNED</b> <u>78/00/1955</u>  |   |
| <b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>  | <b>DATE THEREOF</b>            | <b>NAME OF CEMETERY OR CREMATORY</b>  | <b>LOCATION (City, town, or county) (State)</b> |
| <u>Burial</u>  | <u>11/27/55</u>                | <u>Grasonville, Md.</u>   | <u>Grasonville, Md.</u>                         |
| <b>24. REC'D BY REGISTRAR</b>  | <b>REGISTRAR'S SIGNATURE</b>   | <b>25. FUNERAL DIRECTOR'S SIGNATURE</b>   | <b>ADDRESS</b>                                  |
| <u>11/26/55</u>  | <u>N. H. Neeris</u>            | <u>James B. Whitt</u>   | <u>Coxton, Md.</u>                              |

BUREAU V. S.

DEC 2 1955

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11246

11254

## CERTIFICATE OF DEATH

Reg. Dist. No. 290...

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH:   |  |   |  | 2. USUAL RESIDENCE (HOME) OF DECEASED:   |  |   |  |
| COUNTY <b>TALBOT</b>   |  | MARYLAND  |  | STATE <b>MD</b>  |  | COUNTY <b>TALBOT</b>  |  |
| CITY (If outside corporate limits, write RURAL OR and give nearest town)<br><b>X TOWN TRAPPE</b>   |  | LENGTH OF STAY (in this place)<br><b>9 yrs.</b>   |  | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>TRAPPE</b> <b>X</b> |  |   |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br><b>90 MARSHALL'S NURSING HOME</b>   |  |   |  | STREET ADDRESS (If rural give location)<br><b>1</b>  |  |   |  |
| 3. NAME OF DECEASED: (First) (Middle) (Last)<br><b>ADA E. GREENLEY</b>   |  |   |  | 4. DATE (Month) (Day) (Year) OF DEATH: <b>NOV 25 1955</b>  |  |   |  |
| 5. SEX: <b>FEMALE</b>  |  | 6. COLOR OR RACE: <b>WHITE</b>  |  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>WIDOW</b>                                       |  | 8. DATE OF BIRTH: <b>MAR. 23. 1877</b>                            |  |
| 9. AGE last birthday: <b>78</b> yrs.   |  | 10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):  |  | 10B. KIND OF BUSINESS OR INDUSTRY:   |  | 9. AGE last birthday: <b>78</b> yrs.                              |  |
| 11. BIRTHPLACE (State or foreign country): <b>MARYLAND</b>   |  |   |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>   |  |   |  |
| 13. FATHER'S NAME: <b>ELIJAH MARSHALL</b>  |  |   |  | 14. MOTHER'S MARYEN NAME: <b>ANNIE E SATCHELL</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)  |  |   |  | 16. SOCIAL SECURITY NO.  |  |   |  |
| 17. INFORMANT & ADDRESS: <b>MRS. DENNY MARSHALL-TRAPPE, MD.</b>  |  |   |  |  |  |   |  |
| 18. MEDICAL CERTIFICATION  |  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH                                  |  |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |  |   |  |  |  |   |  |
| IMMEDIATE CAUSE (A) <b>420.1</b> <b>Coronary occlusion</b>   |  |   |  |  |  | <b>1/2 hr</b>   |  |
| ANTECEDENT CAUSE (S) DUE TO (B) <b>Coronary Heart Disease</b>  |  |   |  |  |  | <b>4 months</b>   |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C) <b>Hypertension</b>   |  |   |  |  |  | <b>3 yrs</b>  |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.   |  |   |  |  |  |   |  |
| 19A. DATE OF OPERATION: <b>0</b>   |  |   |  | 19B. MAJOR FINDINGS OF OPERATION   |  |   |  |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |  |  |   |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)  |  | 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?   |  |   |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |  | 21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |  |   |  |
| 22. I hereby certify that I attended the deceased from <b>11/9</b> , 19 <b>55</b> , to <b>11/25</b> , 19 <b>55</b> that I last saw the deceased alive on <b>11/25</b> , 19 <b>55</b> , and that death occurred at <b>1:45</b> M, from the causes and on the date stated above. |  |   |  |  |  |   |  |
| SIGNATURE <b>Louise Mangano</b>  |  |   |  | ADDRESS <b>Cambridge Md</b>  |  | DATE SIGNED <b>11/25/55</b>                                       |  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>   |  | DATE THEREOF <b>11-27-55</b>  |  | NAME OF CEMETERY OR CREMATORY <b>LANDING NECK CEMETERY</b>   |  | LOCATION (City, town, or county) (State) <b>TRAPPE, TALBOT MD</b> |  |
| DATE REC'D BY LOCAL REGISTRAR <b>11-26-55</b>  |  | REGISTRAR'S SIGNATURE <b>N.A. Neer</b>  |  | 24. FUNERAL DIRECTOR ADDRESS <b>MAURICE E. NEWNAM &amp; SON - EASTON, MD.</b>                        |  |   |  |

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NOV 30 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11247

## 11234 CERTIFICATE OF DEATH

Reg. Dist. No. 290

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH:   |  |  |  | 2. USUAL RESIDENCE (HOME) OF DECEASED:  |  |  |  |
| COUNTY <u>Talbot</u>   |  | MARYLAND   |  | STATE <u>Maryland</u> COUNTY <u>Dorchester</u>  |  |  |  |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>40 EASTON</u>  |  | LENGTH OF STAY (in this place) <u>2 1/2 minutes</u>  |  | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hullock</u> <u>09X-2</u> |  |  |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>80 Memorial Hwy.</u>  |  |  |  | STREET ADDRESS (If rural give location)   |  |  |  |
| 3. NAME OF DECEASED: (First) <u>MILTON</u> (Middle) <u>M.</u> (Last) <u>HARPER</u>   |  |  |  | 4. DATE (Month) (Day) (Year) OF DEATH: <u>11</u> <u>14</u> <u>1955</u>                                    |  |  |  |
| 5. SEX: <u>M</u>   |  | 6. COLOR, OR RACE: <u>white</u>  |  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>   |  | 8. DATE OF BIRTH: <u>10-11-1896</u>                        |  |
|  |  |  |  | 9. AGE last birthday: <u>59</u> yrs.  |  | IF UNDER 1 YEAR: Months Days Hours Min.                    |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>   |  | 10B. KIND OF BUSINESS OR INDUSTRY:   |  | 11. BIRTHPLACE (State or foreign country): <u>MARYLAND</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>                    |  |
| 13. FATHER'S NAME: <u>GEORGE HARPER</u>  |  |  |  | 14. MOTHER'S MAIDEN NAME: <u>Minnie Metford</u>   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)  |  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT & ADDRESS: <u>Mrs. Gladys Harper (wife)</u>   |  |  |  |
| 18. MEDICAL CERTIFICATION  |  |  |  |   |  |  |  |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |  |  |  |   |  |  |  |
| 420.1 IMMEDIATE CAUSE  |  |  |  | (A) DUE TO <u>Myocardial Infarct</u>  |  |  |  |
| ANTECEDENT CAUSE (S)   |  |  |  | (B) DUE TO <u>Coronary Occlusion</u>  |  |  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.  |  |  |  | (C) DUE TO  |  |  |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.   |  |  |  |   |  |  |  |
| 19A. DATE OF OPERATION: <u>2</u>   |  |  |  | 19B. MAJOR FINDINGS OF OPERATION  |  |  |  |
| 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |   |  |  |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)   |  | 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?  |  |  |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |  | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |  |  |
| 22. I hereby certify that I attended the deceased from ..... , 19....., to ..... , 19....., that I last saw the deceased alive on ..... , 19....., and that death occurred at <u>9:10 P</u> M, from the causes and on the date stated above. |  |  |  |   |  |  |  |
| SIGNATURE <u>[Signature]</u>   |  | M.D. <u>Corton</u>   |  | ADDRESS <u>18700 V 1955</u>   |  | DATE SIGNED  |  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>   |  | DATE THEREOF <u>11/17/55</u>   |  | NAME OF CEMETERY OR CREMATORY <u>Washington</u>   |  | LOCATION (City, town, or county) (State) <u>Hullock Md</u> |  |
| DATE REC'D BY LOCAL REGISTRAR <u>11-15-55</u>  |  | REGISTRAR'S SIGNATURE <u>N. H. Newen</u>   |  | 24. FUNERAL DIRECTOR <u>Edwards</u>   |  | ADDRESS <u>Belongby East New Market</u>                    |  |

RECEIVED

NOV 30 1955

BUREAU V. S.



## 11235 CERTIFICATE OF DEATH

Reg. Dist. No. 290

|   |                   |  |                   |   |                        |  |                                  |
|---|-------------------|--|-------------------|---|------------------------|--|----------------------------------|
| 1. PLACE OF DEATH:  |                   |  |                   | 2. USUAL RESIDENCE (HOME) OF DECEASED:                                |                        |  |                                  |
| COUNTY <i>Talbot</i>  |                   | MARYLAND   |                   | STATE <i>Md.</i>  |                        | COUNTY <i>Queen Anne's</i>   |                                  |
| CITY (If outside corporate limits, write RURAL OR and give nearest town)  |                   | LENGTH OF STAY (in this place)   |                   | CITY (If outside corporate limits, write RURAL and give nearest town) |                        |  |                                  |
| 40 TOWN <i>Easton</i>   |                   | 24 hrs. 18 min.  |                   | TOWN <i>Sunderville</i> 17X-2   |                        |  |                                  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Memorial Hospital</i>  |                   |  |                   | STREET ADDRESS (If rural give location)                               |                        |  |                                  |
| 3. NAME OF DECEASED: (First) (Middle) (Last)  |                   |  |                   | 4. DATE (Month) (Day) (Year) OF DEATH:                                |                        |  |                                  |
| <i>Garry Harris</i>   |                   |  |                   | <i>11-13 1955</i>   |                        |  |                                  |
| 5. SEX:   | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):  | 8. DATE OF BIRTH: | 9. AGE last birthday yrs.   | IF UNDER 1 YEAR Months | IF UNDER 24 HRS. Days  | Hours Min.                       |
| <i>Male</i>   | <i>Black</i>      | <i>Child</i>   | <i>9-30-55</i>    |   | <i>1</i>               | <i>13</i>  |                                  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):  |                   | 10B. KIND OF BUSINESS OR INDUSTRY:   |                   | 11. BIRTHPLACE (State or foreign country):                            |                        | 12. CITIZEN OF WHAT COUNTRY?   |                                  |
|   |                   |  |                   | <i>Maryland</i>   |                        | <i>W.S.A.</i>  |                                  |
| 13. FATHER'S NAME:  |                   |  |                   | 14. MOTHER'S MAIDEN NAME:   |                        |  |                                  |
| <i>James Harris</i>   |                   |  |                   | <i>Fucille Brown</i>  |                        |  |                                  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)   |                   | 16. SOCIAL SECURITY NO.  |                   | 17. INFORMANT & ADDRESS:  |                        |  |                                  |
| <i>No</i>   |                   |  |                   | <i>James Harris (father)</i>  |                        |  |                                  |
| 18. MEDICAL CERTIFICATION   |                   |  |                   |   |                        |  | INTERVAL BETWEEN ONSET AND DEATH |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |                   |  |                   |   |                        |  |                                  |
| IMMEDIATE CAUSE   |                   |  |                   |   |                        |  |                                  |
| (A) <i>Acute Gastro-enteritis</i>   |                   |  |                   |   |                        |  | <i>2 days</i>                    |
| DUE TO  |                   |  |                   |   |                        |  |                                  |
| (B) <i>Dehydrator Acidosis</i>  |                   |  |                   |   |                        |  | <i>2 days</i>                    |
| DUE TO  |                   |  |                   |   |                        |  |                                  |
| (C) <i>Mal nutrition</i>  |                   |  |                   |   |                        |  | <i>6 wks</i>                     |
| DUE TO  |                   |  |                   |   |                        |  |                                  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.   |                   |  |                   |   |                        |  |                                  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.  |                   |  |                   |   |                        |  |                                  |
| 19A. DATE OF OPERATION:   |                   | 19B. MAJOR FINDINGS OF OPERATION   |                   |   |                        | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                  |
| <i>0</i>  |                   |  |                   |   |                        |  |                                  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                   | 21B. PLACE (Home, farm, factory, street, office bldg., etc.)   |                   | 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?          |                        |  |                                  |
|   |                   |  |                   |   |                        |  |                                  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |                   | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |                   | 21F. HOW DID INJURY OCCUR?  |                        |  |                                  |
|   |                   |  |                   |   |                        |  |                                  |
| 22. I hereby certify that I attended the deceased from <i>11-12-1955</i> , to <i>11-13-1955</i> , that I last saw the deceased alive on <i>11-13-1955</i> , and that death occurred at <i>6:30 P.M.</i> , from the causes and on the date stated above. |                   |  |                   |   |                        |  |                                  |
| SIGNATURE <i>John E. Bayliffe</i>   |                   | ADDRESS <i>205 Earle Ave Easton Md</i>   |                   | DATE SIGNED <i>11/13/55</i>   |                        |  |                                  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)  |                   | DATE THEREOF   |                   | NAME OF CEMETERY OR CREMATORY   |                        | LOCATION (City, town, or county) (State)   |                                  |
|   |                   | <i>11/15/1955</i>  |                   | <i>Goodley church yard</i>  |                        | <i>Sunderville, Md.</i>  |                                  |
| DATE REC'D BY LOCAL REGISTRAR   |                   | REGISTRAR'S SIGNATURE  |                   | 24. FUNERAL DIRECTOR  |                        | ADDRESS  |                                  |
| <i>11/14/55</i>   |                   | <i>N.H. Newices</i>  |                   | <i>Edgar &amp; Lane church, Md.</i>                                   |                        |  |                                  |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 21 1955

BUREAU V. S.

11255

## CERTIFICATE OF DEATH

Reg. Dist. No. 29

|  |                   |  |                      |   |                 |  |              |
|--|-------------------|--|----------------------|---|-----------------|--|--------------|
| 1. PLACE OF DEATH:   |                   |  |                      | 2. USUAL RESIDENCE (HOME) OF DECEASED:                                |                 |  |              |
| COUNTY <u>TALBOT</u>   |                   | MARYLAND   |                      | STATE <u>MD</u>   |                 | COUNTY <u>TALBOT</u>                     |              |
| CITY (If outside corporate limits, write RURAL OR and give nearest town)   |                   | LENGTH OF STAY (in this place)   |                      | CITY (If outside corporate limits, write RURAL and give nearest town) |                 |  |              |
| X TOWN <u>ST. MICHAELS</u>   |                   | <u>LIFE</u>  |                      | X TOWN <u>ST. MICHAELS</u>  |                 |  |              |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS  |                   |  |                      | STREET ADDRESS (If rural give location)                               |                 |  |              |
| 3. NAME OF DECEASED: (First) (Middle) (Last)   |                   |  |                      | 4. DATE (Month) (Day) (Year) OF DEATH:                                |                 |  |              |
| <u>CHARLES HENRY HASKINS</u>   |                   |  |                      | <u>NOV 20 1953</u>  |                 |  |              |
| 5. SEX:  | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):  | 8. DATE OF BIRTH:    | 9. AGE last birthday  | IF UNDER 1 YEAR | IF UNDER 24 HRS.                         |              |
| <u>Male</u>  | <u>Colored</u>    | <u>Married</u>   | <u>APRIL 26-1879</u> | <u>76</u> yrs.  | Months          | Days                                     | Hours   Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                   | 10B. KIND OF BUSINESS OR INDUSTRY:   |                      | 11. BIRTHPLACE (State or foreign country):                            |                 | 12. CITIZEN OF WHAT COUNTRY?             |              |
| <u>CLUSTER SHUCKER</u>   |                   | <u>SEAFOOD</u>   |                      | <u>ST. MICHAELS MD</u>  |                 | <u>U.S.A.</u>                            |              |
| 13. FATHER'S NAME:   |                   |  |                      | 14. MOTHER'S MAIDEN NAME:   |                 |  |              |
| <u>GEORGE HASKINS</u>  |                   |  |                      | <u>UNKNOWN</u>  |                 |  |              |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)   |                   | 16. SOCIAL SECURITY No.  |                      | 17. INFORMANT & ADDRESS:  |                 |  |              |
| <u>NO</u>  |                   | <u>920-09-1950</u>   |                      | <u>Florence H. HASKINS St. Michaels MD</u>                            |                 |  |              |
| 18. MEDICAL CERTIFICATION  |                   |  |                      |   |                 | INTERVAL BETWEEN ONSET AND DEATH         |              |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |                   |  |                      |   |                 |  |              |
| IMMEDIATE CAUSE  |                   |  |                      |   |                 |  |              |
| (A) <u>Acute Thrombosis</u>  |                   |  |                      |   |                 |  |              |
| ANTECEDENT CAUSE (S)   |                   |  |                      |   |                 |  |              |
| (B) <u>Chronic Rheumatism</u>  |                   |  |                      |   |                 |  |              |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.  |                   |  |                      |   |                 |  |              |
| (C) <u>Chronic Anemia</u>  |                   |  |                      |   |                 |  |              |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.   |                   |  |                      |   |                 |  |              |
| 19A. DATE OF OPERATION:  |                   |  |                      | 19B. MAJOR FINDINGS OF OPERATION                                      |                 |  |              |
| <u>0</u>   |                   |  |                      |   |                 |  |              |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |                   |  |                      |   |                 |  |              |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                   | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)   |                      | 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?          |                 |  |              |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |                   | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |                      | 21F. HOW DID INJURY OCCUR?  |                 |  |              |
|  |                   |  |                      |   |                 |  |              |
| 22. I hereby certify that I attended the deceased from ..... 19....., to ..... 19....., that I last saw the deceased alive on <u>Nov 6</u> , 19 <u>53</u> , and that death occurred at <u>10A</u> M, from the causes and on the date stated above. |                   |  |                      |   |                 |  |              |
| SIGNATURE <u>Philip D. Lewis</u>   |                   |  |                      | ADDRESS <u>St. Michaels, Md</u>                                       |                 | DATE SIGNED <u>Nov 22, 53</u>            |              |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)   |                   | DATE THEREOF   |                      | NAME OF CEMETERY OR CREMATORY   |                 | LOCATION (City, town, or county) (State) |              |
| <u>BURIAL</u>  |                   | <u>11/25/53</u>  |                      | <u>THOMAS MEMORIAL CEMETERY</u>                                       |                 | <u>ST. MICHAELS MD</u>                   |              |
| DATE REC'D BY LOCAL REGISTRAR  |                   | REGISTRAR'S SIGNATURE  |                      | 24. FUNERAL DIRECTOR  |                 | ADDRESS                                  |              |
| <u>Nov 23, 1953</u>  |                   | <u>Mrs. Robert E. Balth</u>  |                      | <u>Hampton Harrison</u>   |                 | <u>St. Michaels MD</u>                   |              |

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist.

No. 290

|   |                                   |   |   |  |                                |   |                                |
|---|-----------------------------------|---|---|--|--------------------------------|---|--------------------------------|
| 1. PLACE OF DEATH:  |                                   |   |   | 2. USUAL RESIDENCE (HOME) OF DECEASED:   |                                |   |                                |
| COUNTY <u>Talbot</u>  |                                   | MARYLAND  |   | STATE <u>Md.</u>   |                                | COUNTY <u>Dor.</u>  |                                |
| CITY (If outside corporate limits, write RURAL OR and give nearest town)<br>TOWN <u>Easton</u>  |                                   | LENGTH OF STAY (in this place)<br><u>2 days</u>   |   | CITY (If outside corporate limits write RURAL and give nearest town)<br>OR<br>TOWN <u>Hurlock - Rural</u> <u>09X-2</u>                     |                                |   |                                |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Easton Memorial Hospital</u>   |                                   |   |   | STREET ADDRESS (If rural, give location)<br><u>Near Waddell's Corner</u> ✓   |                                |   |                                |
| 3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last)<br><u>ELLA</u> <u>MAE</u> <u>HOWELL</u>  |                                   |   |   | 4. DATE OF DEATH (Month) (Day) (Year)<br><u>Nov.</u> <u>16</u> , 19 <u>55</u>  |                                |   |                                |
| 5. SEX:<br><u>Female</u>  | 6. COLOR OR RACE:<br><u>Negro</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>  | 8. DATE OF BIRTH:<br><u>May 6, 1925</u> | 9. AGE last birthday: <u>30</u> yrs.   | IF UNDER 1 YEAR<br>Months Days |   | IF UNDER 24 HRS.<br>Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Housework</u>  |                                   | 10b. KIND OF BUSINESS OR INDUSTRY: <u>Home</u>  |   | 11. BIRTHPLACE (State or foreign country): <u>Florida</u>  |                                | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>                                 |                                |
| 13. FATHER'S NAME:<br><u>Richard Thomas</u>   |                                   |   |   | 14. MOTHER'S MAIDEN NAME:<br><u>Lillie Belle Morris</u>  |                                |   |                                |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)<br><u>No</u>  |                                   | 16. SOCIAL SECURITY No.:<br><u>Unknown</u>  |   | 17. INFORMANT & ADDRESS:<br><u>James Howell, Hurlock, Maryland</u>   |                                |   |                                |
| 18. MEDICAL CERTIFICATION   |                                   |   |   |  |                                |   |                                |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:  |                                   |   |   |  |                                | INTERVAL BETWEEN ONSET AND DEATH  |                                |
| (a) <u>916.0</u> <u>Toxemia</u><br>Immediate cause DUE TO   |                                   |   |   |  |                                |   |                                |
| (b) <u>2nd and 3rd degree burns entire body.</u><br>Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause DUE TO   |                                   |   |   |  |                                | <u>2 days</u>   |                                |
| (c) <u>stating underlying cause last</u>  |                                   |   |   |  |                                |   |                                |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.   |                                   |   |   |  |                                |   |                                |
| 19a. DATE OF OPERATION: <u>0</u>  |                                   |   |   | 19b. MAJOR FINDING OF OPERATION:   |                                |   |                                |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                                   | 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>Home</u>                                |   | 21c. (City or town) (County)<br><u>Hurlock</u> <u>Dor.</u> <u>09 Maryland</u>  |                                | 20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/> (State) |                                |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Nov.</u> <u>14</u> <u>55</u> <u>1P</u> <u>M.</u>   |                                   | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> |   | 21f. HOW DID INJURY OCCUR?<br><u>Kerosene Refrigerator exploded.</u>   |                                |   |                                |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . |                                   |   |   |  |                                |   |                                |
| SIGNATURE<br><u>John Mouch</u>  |                                   |   |   | CHIEF MEDICAL EXAMINER<br>DEPUTY MEDICAL EXAMINER<br>M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/> DATE SIGNED <u>Nov. 17 '55</u> |                                |   |                                |
| 23. BURIAL, CREMATION, REMOVAL (Specify):<br><u>Burial</u>  |                                   | DATE THEREOF<br><u>Nov. 19, 1955</u>  |   | NAME OF CEMETERY OR CREMATORY<br><u>Washington Cemetery</u>  |                                | LOCATION (City, town, or county) (State)<br><u>Near Hurlock, Maryland</u>     |                                |
| DATE REC'D BY LOCAL REG.<br><u>11/17/55</u>   |                                   | REGISTRAR'S SIGNATURE<br><u>N. H. Neerich</u>   |   | 24. FUNERAL DIRECTOR<br><u>J. J. Frampton and Son, Federalsburg, Md.</u>   |                                | ADDRESS   |                                |

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11251

11256

## CERTIFICATE OF DEATH

Reg. Dist. No. 291

|  |                  |  |                       |   |                               |  |  |
|--|------------------|--|-----------------------|---|-------------------------------|--|--|
| <b>1. PLACE OF DEATH</b>   |                  |  |                       | <b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>                            |                               |  |  |
| COUNTY <i>Talbot</i>   |                  | MARYLAND   |                       | STATE <i>Maryland</i>   |                               | COUNTY <i>Talbot</i>                     |  |
| CITY (If outside corporate limits, write RURAL OR end give nearest town)   |                  | LENGTH OF STAY (in this place)   |                       | CITY (If outside corporate limits, write RURAL end give nearest town)   |                               | OR TOWN                                  |  |
| <i>X TOWN Rural - St. Michaels</i>   |                  | <i>6 yr.</i>   |                       | <i>rural St. Michaels</i>   |                               | <i>X</i>                                 |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Church Neck, Oakwood Inn</i>  |                  |  |                       | STREET ADDRESS (If rural give location) <i>Church Neck, Oakwood Inn</i> |                               |  |  |
| <b>3. NAME OF DECEASED</b> (Type or Print)   |                  |  |                       | <b>4. DATE OF DEATH</b> (Month) (Day) (Year)                            |                               |  |  |
| <i>John Edward Jaeger, Jr</i>  |                  |  |                       | <i>November 30 1955</i>   |                               |  |  |
| 5. SEX   | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)   | 8. DATE OF BIRTH      | 9. AGE last birthday  | IF UNDER 1 YEAR               | IF UNDER 24 HRS.                         |  |
| <i>M</i>   | <i>W</i>         | <i>Divorced</i>  | <i>8 January 1921</i> | <i>34</i> yrs.  | Months <i>—</i> Days <i>—</i> | Hours <i>—</i> Min. <i>—</i>             |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                  | 10b. KIND OF BUSINESS OR INDUSTRY  |                       | 11. BIRTHPLACE (State or foreign country)                               |                               | 12. CITIZEN OF WHAT COUNTRY?             |  |
| <i>Meat Cutter</i>   |                  | <i>Meat Packing</i>  |                       | <i>New York</i>   |                               | <i>U.S.</i>                              |  |
| 13. FATHER'S NAME  |                  |  |                       | 14. MOTHER'S MAIDEN NAME  |                               |  |  |
| <i>John Edward Jaeger, Sr</i>  |                  |  |                       | <i>Frieda Marie Ebelein</i>   |                               |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)  |                  | 16. SOCIAL SECURITY NO.  |                       | 17. INFORMANT & ADDRESS   |                               |  |  |
| <i>Yes</i>   |                  | <i>1942-1944</i>   |                       | <i>Father - Same</i>  |                               |  |  |
| <b>18. MEDICAL CERTIFICATION</b>   |                  |  |                       |   |                               | INTERVAL BETWEEN ONSET AND DEATH         |  |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |                  |  |                       |   |                               |  |  |
| <i>443X IMMEDIATE CAUSE (A) Pulmonary Edema</i>  |                  |  |                       |   |                               | <i>15 min</i>                            |  |
| ANTECEDENT CAUSE(S) DUE TO   |                  |  |                       |   |                               |  |  |
| <i>(B) Congestive Heart Failure</i>  |                  |  |                       |   |                               | <i>2 wk</i>                              |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO  |                  |  |                       |   |                               |  |  |
| <i>(C) Hypertensive Cardiovascular Disease</i>   |                  |  |                       |   |                               | <i>3 yr.</i>                             |  |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.   |                  |  |                       |   |                               |  |  |
| <i>Extreme Obesity</i>   |                  |  |                       |   |                               |  |  |
| 19a. DATE OF OPERATION   |                  | 19b. MAJOR FINDINGS OF OPERATION   |                       | 20. AUTOPSY?  |                               |  |  |
| <i>—</i>   |                  | <i>—</i>   |                       | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>     |                               |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                  | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)                                 |                       | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)            |                               |  |  |
| <i>—</i>   |                  | <i>—</i>   |                       | <i>—</i>  |                               |  |  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour)  |                  | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |                       | 21f. HOW DID INJURY OCCUR?  |                               |  |  |
| <i>—</i>   |                  | <i>M.</i>  |                       | <i>—</i>  |                               |  |  |
| <b>22. I hereby certify</b> that I attended the deceased from <i>22 November 1955</i> , to <i>30 Nov 1955</i> , that I last saw the deceased alive on <i>29 Nov</i> , 19 <i>55</i> , and that death occurred at <i>1:00 A.M.</i> from the causes and on the date stated above. |                  |  |                       |   |                               |  |  |
| SIGNATURE <i>K. Kane Wrath</i>   |                  |  |                       | ADDRESS (Street, city, town, state) <i>St. Michaels Maryland</i>        |                               | DATE SIGNED <i>11-30-55</i>              |  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)   |                  | DATE THEREOF   |                       | NAME OF CEMETERY OR CREMATORY   |                               | LOCATION (City, town, or county) (State) |  |
| <i>Burial</i>  |                  | <i>12/2/55</i>   |                       | <i>Meadowridge Mem. Pk.</i>   |                               | <i>Elkridge, Md.</i>                     |  |
| 24. REC'D BY REGISTRAR   |                  | REGISTRAR'S SIGNATURE  |                       | 25. FUNERAL DIRECTOR'S SIGNATURE  |                               | ADDRESS                                  |  |
| <i>DEC 2 1955</i>  |                  | <i>Mr. E. A. Leth</i>  |                       | <i>Dr. J. T. Lickner &amp; Sons - Baeto 17</i>                          |                               | <i>md</i>                                |  |

MASSACHUSETTS DEPARTMENT OF HEALTH-BALTIMORE 18

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11252

## 11238 CERTIFICATE OF DEATH

Reg. Dist. No. 290....

|  |                   |   |  |   |  |  |                                  |
|--|-------------------|---|--|---|--|--|----------------------------------|
| 1. PLACE OF DEATH:   |                   |   |  | 2. USUAL RESIDENCE (HOME) OF DECEASED:                                |  |  |                                  |
| COUNTY <u>Talbot</u>   |                   | MARYLAND  |  | STATE <u>Maryland</u> COUNTY <u>Talbot</u>                            |  |  |                                  |
| CITY (If outside corporate limits, write RURAL OR and give nearest town)   |                   | LENGTH OF STAY (in this place)                    |  | CITY (If outside corporate limits, write RURAL and give nearest town) |  |  |                                  |
| 40 TOWN <u>Easton</u>  |                   | 21 hrs.   |  | TOWN <u>Avalon</u>  |  |  |                                  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS  |                   |   |  | STREET ADDRESS (If rural give location)                               |  |  |                                  |
| 80 <u>Easton Memorial Hospital</u>   |                   |   |  | 1   |  |  |                                  |
| 3. NAME OF DECEASED: (First) (Middle) (Last)   |                   |   |  | 4. DATE (Month) (Day) (Year)  |  |  |                                  |
| DECEASED: (Type or Print) <u>John P Kapisak</u>  |                   |   |  | OF DEATH: <u>11 7 1955</u>  |  |  |                                  |
| 5. SEX:  | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): | 8. DATE OF BIRTH:  | 9. AGE last birthday  | IF UNDER 1 YEAR                                | IF UNDER 24 HRS.   |                                  |
| M  | W                 |   | <u>April 17, 1890</u>  | 65 yrs.   | Months   | Days   | Hours                            |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):   |                   |   | 10B. KIND OF BUSINESS OR INDUSTRY:   | 11. BIRTHPLACE (State or foreign country):                            |  | 12. CITIZEN OF WHAT COUNTRY?   |                                  |
|  |                   |   |  | <u>Maryland</u>   |  | <u>USA</u>   |                                  |
| 13. FATHER'S NAME:   |                   |   |  | 14. MOTHER'S MAIDEN NAME:   |  |  |                                  |
| <u>Paul Kapisak</u>  |                   |   |  | <u>Anna Novak</u>   |  |  |                                  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)  |                   |   | 16. SOCIAL SECURITY NO.  |   | 17. INFORMANT & ADDRESS:                       |  |                                  |
| 9  |                   |   |  |   | <u>Mrs. Laura J. Kapisak (wife)</u>            |  |                                  |
| 18. MEDICAL CERTIFICATION  |                   |   |  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |                   |   |  |   |  |  |                                  |
| 422.1 IMMEDIATE CAUSE  |                   |   |  |   |  |  |                                  |
| (A) <u>cardiac failure</u>   |                   |   |  |   |  |  | <u>4 days</u>                    |
| DUE TO   |                   |   |  |   |  |  |                                  |
| ANTECEDENT CAUSE (S)   |                   |   |  |   |  |  |                                  |
| (B) <u>arteriosclerotic cardiovascular</u>   |                   |   |  |   |  |  | <u>-</u>                         |
| DUE TO   |                   |   |  |   |  |  |                                  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.  |                   |   |  |   |  |  |                                  |
| (C)  |                   |   |  |   |  |  |                                  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.   |                   |   |  |   |  |  |                                  |
| 19A. DATE OF OPERATION:  |                   |   | 19B. MAJOR FINDINGS OF OPERATION   |   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                  |
| 0  |                   |   |  |   |  |  |                                  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                   |   | 21B. PLACE (Home, farm, factory, street, office bldg., etc.)   |   | 21C. WHERE DID (City or town) (County) (State) |  |                                  |
|  |                   |   |  |   |  |  |                                  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |                   |   | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |   | 21F. HOW DID INJURY OCCUR?                     |  |                                  |
|  |                   |   |  |   |  |  |                                  |
| 22. I hereby certify that I attended the deceased from <u>11-6</u> , 19 <u>55</u> , to <u>11-7</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11-7</u> , 19 <u>55</u> , and that death occurred at <u>1:00</u> P. M., from the causes and on the date stated above. |                   |   |  |   |  |  |                                  |
| SIGNATURE  |                   |   |  | ADDRESS   |  | DATE SIGNED  |                                  |
| <u>[Signature]</u>   |                   |   |  | <u>M. D. Strickland M.D.</u>  |  | <u>11-7-55</u>   |                                  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)   |                   | DATE THEREOF                                      |  | NAME OF CEMETERY OR CREMATORY   |  | LOCATION (City, town, or county) (State)   |                                  |
| <u>Burial</u>  |                   | <u>Nov. 10, 1955</u>                              |  | <u>Tilghman Cemetery</u>  |  | <u>Tilghman Md</u>   |                                  |
| DATE REC'D BY LOCAL REGISTRAR  |                   | REGISTRAR'S SIGNATURE                             |  | 24. FUNERAL DIRECTOR  |  | ADDRESS  |                                  |
| <u>11-8-55</u>   |                   | <u>N. L. Neer</u>                                 |  | <u>St. Ambrose</u>  |  | <u>St. Ambrose, Md</u>   |                                  |

RECEIVED

NOV 15 1933

BUREAU V. S.

1

## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11237 CERTIFICATE OF DEATH

11253

Reg. Dist. No. 290.....

|  |                              |  |   |  |                                |   |  |
|--|------------------------------|--|---|--|--------------------------------|---|--|
| <b>1. PLACE OF DEATH</b>   |                              |  |   | <b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>   |                                |   |  |
| COUNTY <u>Talbot</u>   |                              | MARYLAND   |   | STATE <u>Maryland</u> COUNTY <u>Talbot</u>   |                                |   |  |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR TOWN <u>Easton</u>   |                              | LENGTH OF STAY (in this place)<br><u>10 1/2 hrs</u>  |   | CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR TOWN <u>Easton, Md</u> |                                | X   |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br><u>Memorial Hosp.</u>   |                              |  |   | STREET ADDRESS (If rural give location)<br><u>RFD # 4</u>  |                                |   |  |
| <b>3. NAME OF DECEASED</b> (First) (Middle) (Last)<br><u>Baby Boy Lane</u>   |                              |  |   | <b>4. DATE OF DEATH</b> (Month) (Day) (Year)<br><u>November 25 19 55</u>                           |                                |   |  |
| 5. SEX<br><u>M</u>   | 6. COLOR OR RACE<br><u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)   | 8. DATE OF BIRTH<br><u>November 25 55</u> | 9. AGE last birthday<br>yrs. <u>—</u>  | IF UNDER 1 YEAR<br>Months Days |   | IF UNDER 24 HRS.<br>Hours Min.<br><u>10 30</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                              | 10b. KIND OF BUSINESS OR INDUSTRY  |   | 11. BIRTHPLACE (State or foreign country)<br><u>Md.</u>  |                                | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA.</u> |  |
| 13. FATHER'S NAME<br><u>William L. Lane</u>  |                              |  |   | 14. MOTHER'S MAIDEN NAME<br><u>Alice Bartlett</u>  |                                |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)   |                              | 16. SOCIAL SECURITY NO.  |   | 17. INFORMANT & ADDRESS<br><u>Mrs. Wm. C. Lane - Easton R. D. #4</u>                               |                                |   |  |
| <b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>   |                              |  |   | <b>18. MEDICAL CERTIFICATION</b>   |                                |   |  |
| 762.5 IMMEDIATE CAUSE (A) <u>Cerebral Anoxia</u>   |                              |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>20 hrs</u>  |                                |   |  |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Prematurity</u>  |                              |  |   |  |                                |   |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)   |                              |  |   |  |                                |   |  |
| <b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>  |                              |  |   |  |                                |   |  |
| 19a. DATE OF OPERATION   |                              | 19b. MAJOR FINDINGS OF OPERATION   |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                |                                |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                              | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)                                 |   | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)                                       |                                |   |  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour)  |                              | 21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |   | 21f. HOW DID INJURY OCCUR?   |                                |   |  |
| <b>22. I hereby certify</b> that I attended the deceased from <u>11-25</u> , 19 <u>55</u> , to <u>11-25</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11-25</u> , 19 <u>55</u> , and that death occurred at <u>9:20 P.M.</u> from the causes and on the date stated above. |                              |  |   |  |                                |   |  |
| SIGNATURE<br><u>John P. Baybutt</u> M.D.   |                              |  |   | ADDRESS (Street, city, town, state)<br><u>Easton, Md</u>   |                                | DATE SIGNED<br><u>11/25/55</u>              |  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Body incinerated at Memorial Hospital Easton Md</u>   |                              | DATE THEREOF   |   | NAME OF CEMETERY OR CREMATORY  |                                | LOCATION (City, town, or county) (State)    |  |
| 24. REC'D BY REGISTRAR<br><u>N.H. Neerue</u>   |                              | REGISTRAR'S SIGNATURE  |   | 25. FUNERAL DIRECTOR'S SIGNATURE<br><u>Memorial Hospital Easton Md</u>                             |                                | ADDRESS                                     |  |
| DATE <u>11-26-55</u>   |                              |  |   |  |                                |   |  |

20X5324301

# CERTIFICATE OF DEATH

DATE OF DEATH

AGE

SEX

CAUSE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

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PLACE OF DEATH

BUREAU V. S.

NOV 20 1955

RECEIVED

MASSACHUSETTS

DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
BALTIMORE, MARYLAND  
RECEIVED  
NOV 20 1955



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11254

11239

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

|  |                                |  |  |   |   |  |                                |
|--|--------------------------------|--|--|---|---|--|--------------------------------|
| 1. PLACE OF DEATH:   |                                |  |  | 2. USUAL RESIDENCE (HOME) OF DECEASED:  |   |  |                                |
| COUNTY <u>Talbot</u>   |                                | MARYLAND   |  | STATE <u>Maryland</u> COUNTY <u>Queen Anne</u>  |   |  |                                |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>40 Easton</u>  |                                | LENGTH OF STAY (in this place) <u>31 hrs. 20 mins.</u>   |  | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Centreville</u> <u>17X-2</u> |   |  |                                |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hospital</u>   |                                |  |  | STREET ADDRESS (If rural give location) <u>Pa</u>   |   |  |                                |
| 3. NAME OF DECEASED: (First) (Middle) (Last)   |                                |  |  | 4. DATE (Month) (Day) (Year)  |   |  |                                |
| <u>Henry C. Lewis</u>  |                                |  |  | <u>Nov. 9 1903</u>  |   |  |                                |
| 5. SEX: <u>Male</u>  | 6. COLOR OR RACE: <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>married</u>   | 8. DATE OF BIRTH: <u>Nov. 28, 1886</u> | 9. AGE last birthday <u>68</u> yrs.   | IF UNDER 1 YEAR<br>Months Days Hours Min. |  | IF UNDER 24 HRS.<br>Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Mechanic</u>   |                                | 10B. KIND OF BUSINESS OR INDUSTRY:   |  | 11. BIRTHPLACE (State or foreign country): <u>Maryland</u>  |   | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>                                       |                                |
| 13. FATHER'S NAME: <u>John L. Lewis</u>  |                                |  |  | 14. MOTHER'S MAIDEN NAME: <u>Evelia McClyment</u>   |   |  |                                |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>9</u>   |                                | 16. SOCIAL SECURITY NO. <u>#214-32-7321</u>  |  | 17. INFORMANT & ADDRESS: <u>Mrs Myrtle Lewis (wife)</u>   |   |  |                                |
| 18. MEDICAL CERTIFICATION  |                                |  |  |   |   | INTERVAL BETWEEN ONSET AND DEATH   |                                |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |                                |  |  |   |   |  |                                |
| IMMEDIATE CAUSE (A) <u>Carcinoma of lung</u>   |                                |  |  |   |   |  |                                |
| ANTECEDENT CAUSE (B) <u>163X</u>   |                                |  |  |   |   |  |                                |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.  |                                |  |  |   |   |  |                                |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.  |                                |  |  |   |   |  |                                |
| 19A. DATE OF OPERATION: <u>2</u>   |                                | 19B. MAJOR FINDINGS OF OPERATION   |  |   |   | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.  |  | 21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)  |   |  |                                |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |                                | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |   |  |                                |
| 22. I hereby certify that I attended the deceased from ..... 19....., to ..... 19....., that I last saw the deceased alive on ..... 19....., and that death occurred at <u>12<sup>25</sup></u> A.M., from the causes and on the date stated above. |                                |  |  |   |   |  |                                |
| SIGNATURE <u>Edw. Schmitt</u>  |                                | M.D. <u>Easton</u>   |  | DATE SIGNED <u>22 9/10/1953</u>   |   |  |                                |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>   |                                | DATE THEREOF <u>11-11-55</u>   |  | NAME OF CEMETERY OR CREMATORY <u>Chesterfield</u>   |   | LOCATION (City, town, or county) (State) <u>Centreville Md</u>                   |                                |
| DATE REC'D BY LOCAL REGISTRAR <u>11/10/55</u>  |                                | REGISTRAR'S SIGNATURE <u>N.H. Neirer</u>   |  | FUNERAL DIRECTOR <u>Barton Bros. Centreville, Maryland</u>  |   | ADDRESS  |                                |



BUREAU V. S.

NOV 29 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11255

11240

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

|   |                   |  |                                    |  |                 |  |                  |
|---|-------------------|--|------------------------------------|--|-----------------|--|------------------|
| 1. PLACE OF DEATH:  |                   |  |                                    | 2. USUAL RESIDENCE (HOME) OF DECEASED:   |                 |  |                  |
| COUNTY <u>Talbot</u>  |                   | MARYLAND   |                                    | STATE <u>Md.</u>   |                 | COUNTY <u>Queen Anne's</u>               |                  |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>40</u> <u>Easton</u>  |                   | LENGTH OF STAY (in this place) <u>2 days</u>   |                                    | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>5th Ave. Easton Md.</u> |                 | <u>05X-2</u>                             |                  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hospital</u>  |                   |  |                                    | STREET ADDRESS (If rural give location) <u>5th Ave. Easton Md.</u>                                       |                 |  |                  |
| 3. NAME OF DECEASED: (First) (Middle) (Last)  |                   |  |                                    | 4. DATE (Month) (Day) (Year) OF DEATH:   |                 |  |                  |
| <u>Henshelle Liles</u>  |                   |  |                                    | <u>11-10-1955</u>  |                 |  |                  |
| 5. SEX:   | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Specify):  | 8. DATE OF BIRTH:                  | 9. AGE last birthday   | IF UNDER 1 YEAR |  | IF UNDER 24 HRS. |
| <u>Female</u>   | <u>White</u>      | <u>Widowed</u>   | <u>Dec. 18-1885</u>                | <u>70</u> yrs.   | Months          | Days                                     | Hours            |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):  |                   |  | 10b. KIND OF BUSINESS OR INDUSTRY: | 11. BIRTHPLACE (State or foreign country):   |                 | 12. CITIZEN OF WHAT COUNTRY?             |                  |
|   |                   |  |                                    | <u>Md.</u>   |                 | <u>U.S.C.</u>                            |                  |
| 13. FATHER'S NAME:  |                   |  |                                    | 14. MOTHER'S MAIDEN NAME:  |                 |  |                  |
| <u>Isaac Anderson</u>   |                   |  |                                    | <u>Hattie Clough</u>   |                 |  |                  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service)  |                   |  |                                    | 16. SOCIAL SECURITY NO.  |                 | 17. INFORMANT & ADDRESS:                 |                  |
|   |                   |  |                                    |  |                 | <u>Mrs. J. Kemp Stevens (sister)</u>     |                  |
| 18. MEDICAL CERTIFICATION   |                   |  |                                    |  |                 | INTERVAL BETWEEN ONSET AND DEATH         |                  |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |                   |  |                                    |  |                 |  |                  |
| 420.1 IMMEDIATE CAUSE   |                   |  |                                    |  |                 |  |                  |
| (A) DUE TO <u>myocardial infarction</u>   |                   |  |                                    |  |                 | 3 days                                   |                  |
| ANTECEDENT CAUSE (S)  |                   |  |                                    |  |                 |  |                  |
| (B) DUE TO <u>due to atherosclerotic</u>  |                   |  |                                    |  |                 |  |                  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.   |                   |  |                                    |  |                 |  |                  |
| (C) <u>coronary thrombosis</u>  |                   |  |                                    |  |                 |  |                  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.  |                   |  |                                    |  |                 |  |                  |
| 19a. DATE OF OPERATION:   |                   |  |                                    | 19b. MAJOR FINDINGS OF OPERATION   |                 |  |                  |
| <u>0</u>  |                   |  |                                    |  |                 |  |                  |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |                   |  |                                    |  |                 |  |                  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                   | 21b. PLACE (Home, farm, factory, street, office bldg., etc.)   |                                    | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)   |                 |  |                  |
|   |                   |  |                                    |  |                 |  |                  |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY   |                   | 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |                                    | 21f. HOW DID INJURY OCCUR?   |                 |  |                  |
|   |                   |  |                                    |  |                 |  |                  |
| 22. I hereby certify that I attended the deceased from ..... , 19....., to ..... , 19....., that I last saw the deceased alive on <u>10th</u> , 19 <u>55</u> , and that death occurred at <u>12:30 AM</u> , from the causes and on the date stated above. |                   |  |                                    |  |                 |  |                  |
| SIGNATURE <u>Thos. H. Harrison</u>  |                   |  |                                    | ADDRESS <u>Easton, Maryland</u>  |                 | DATE SIGNED <u>14th Nov 55</u>           |                  |
| M. D.   |                   |  |                                    |  |                 |  |                  |
| 23. BURIAL, CREMATION, REMOVAL—(SPECIFY)  |                   | DATE THEREOF   |                                    | NAME OF CEMETERY OR CREMATORY  |                 | LOCATION (City, town, or county) (State) |                  |
| <u>Burial</u>   |                   | <u>Nov. 3, 1955</u>  |                                    | <u>Easton</u>  |                 | <u>Easton, Md.</u>                       |                  |
| DATE REC'D BY LOCAL REGISTRAR   |                   | REGISTRAR'S SIGNATURE  |                                    | 24. FUNERAL DIRECTOR   |                 | ADDRESS                                  |                  |
| <u>11/11/55</u>   |                   | <u>M.A. Newberry</u>   |                                    | <u>J. Edgar Brown</u>  |                 | <u>Easton</u>                            |                  |

RECEIVED

NOV 21 1955

BUREAU V. S.

RECEIVED

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filled with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11257

## CERTIFICATE OF DEATH

11256

Reg. Dist. No. 290

|   |                         |   |                         |   |                        |   |            |
|---|-------------------------|---|-------------------------|---|------------------------|---|------------|
| <b>1. PLACE OF DEATH</b>  |                         |   |                         | <b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>  |                        |   |            |
| COUNTY <u>talbot</u>  |                         | MARYLAND  |                         | STATE <u>MD.</u>  |                        | COUNTY <u>Ken +</u>                             |            |
| CITY (If outside corporate limits, write RURAL and give nearest town)   |                         | LENGTH OF STAY (in this place)  |                         | CITY (If outside corporate limits, write RURAL and give nearest town)                   |                        |   |            |
| OR TOWN <u>x</u> <u>frappe</u>  |                         | <u>43 yrs.</u>  |                         | OR TOWN <u>Chester town</u>   |                        | <u>x</u>  |            |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS   |                         |   |                         | STREET ADDRESS (If rural give location)   |                        |   |            |
| <u>00</u>   |                         |   |                         | <u>Route III</u>  |                        | <u>1</u>  |            |
| <b>3. NAME OF DECEASED</b> (Type or Print)  |                         |   |                         | <b>4. DATE OF DEATH</b> (Month) (Day) (Year)  |                        |   |            |
| (First) (Middle) (Last) <u>Samuel Clark Lindsey</u>   |                         |   |                         | <u>11</u> <u>29</u> <u>1955</u>   |                        |   |            |
| <b>5. SEX</b>   | <b>6. COLOR OR RACE</b> | <b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>   | <b>8. DATE OF BIRTH</b> | <b>9. AGE last birthday</b>   | <b>IF UNDER 1 YEAR</b> | <b>IF UNDER 24 HRS.</b>                         |            |
| <u>m</u>  | <u>col</u>              | <u>widowed</u>  | <u>5/20/65</u>          | <u>90</u> yrs.  | Months                 | Days  | Hours Min. |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)  |                         | <b>10b. KIND OF BUSINESS OR INDUSTRY</b>  |                         | <b>11. BIRTHPLACE</b> (State or foreign country)  |                        | <b>12. CITIZEN OF WHAT COUNTRY?</b>             |            |
| <u>laborer</u>  |                         | <u>Domestic</u>   |                         | <u>Maryland</u>   |                        | <u>U.S.A.</u>                                   |            |
| <b>13. FATHER'S NAME</b>  |                         |   |                         | <b>14. MOTHER'S MAIDEN NAME</b>   |                        |   |            |
| <u>Charles H. Lindsey</u>   |                         |   |                         | <u>Anna Rebecca Brice</u>   |                        |   |            |
| <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)  |                         | <b>16. SOCIAL SECURITY NO.</b>  |                         | <b>17. INFORMANT &amp; ADDRESS</b>  |                        |   |            |
| <u>(If Yes, give war or dates of service)</u>   |                         | <u></u>   |                         | <u>George P. Lindsey, Pomonok, Md</u>   |                        |   |            |
| <b>18. MEDICAL CERTIFICATION</b>  |                         |   |                         | <b>INTERVAL BETWEEN ONSET AND DEATH</b>   |                        |   |            |
| <b>DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>   |                         |   |                         |   |                        |   |            |
| <u>420.1</u> IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>   |                         |   |                         | <u>hrs</u>  |                        |   |            |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary Atherosclerosis</u>  |                         |   |                         | <u>years</u>  |                        |   |            |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <u>Generalized Atherosclerosis</u>  |                         |   |                         | <u>years</u>  |                        |   |            |
| <b>11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>  |                         |   |                         |   |                        |   |            |
| <b>19a. DATE OF OPERATION</b>   |                         | <b>19b. MAJOR FINDINGS OF OPERATION</b>   |                         | <b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                        |   |            |
| <u></u>   |                         | <u></u>   |                         |   |                        |   |            |
| <b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>   |                         | <b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>                                 |                         | <b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)                     |                        |   |            |
| <u></u>   |                         | <u></u>   |                         | <u></u>   |                        |   |            |
| <b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)  |                         | <b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |                         | <b>21f. HOW DID INJURY OCCUR?</b>   |                        |   |            |
| <u></u>   |                         | <u></u>   |                         | <u></u>   |                        |   |            |
| <b>22. I hereby certify</b> that I attended the deceased from <u>1-1</u> , 19 <u>50</u> , to <u>11-29</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>11-25</u> , 19 <u>51</u> , and that death occurred at <u>3:30</u> M., from the causes and on the date stated above. |                         |   |                         |   |                        |   |            |
| <b>SIGNATURE</b>  |                         |   |                         | <b>ADDRESS</b> (Street, city, town, state)  |                        | <b>DATE SIGNED</b>                              |            |
| <u>W. J. Buell</u>  |                         |   |                         | <u>Poston Maryland</u>  |                        | <u>12-2-51</u>                                  |            |
| <b>23. BURIAL, CREMATION, REMOVAL, (SPECIFY)</b>  |                         | <b>DATE THEREOF</b>   |                         | <b>NAME OF CEMETERY OR CREMATORY</b>  |                        | <b>LOCATION</b> (City, town, or county) (State) |            |
| <u>Burial</u>   |                         | <u>12/19/55</u>   |                         | <u>Quaker Neck Cemetery</u>   |                        | <u>Pomonok, Md.</u>                             |            |
| <b>24. REC'D BY REGISTRAR</b>   |                         | <b>REGISTRAR'S SIGNATURE</b>  |                         | <b>25. FUNERAL DIRECTOR'S SIGNATURE</b>   |                        | <b>ADDRESS</b>                                  |            |
| <u>12/3/55</u>  |                         | <u>N. H. Neerius</u>  |                         | <u>James B. Boshell</u>   |                        | <u>Easton, Md.</u>                              |            |

11958

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

# CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. RACE

5. BIRTH DATE

6. BIRTH PLACE

7. MARRIAGE DATE

8. MARRIAGE PLACE

9. OCCUPATION

10. CAUSE OF DEATH

11. PLACE OF DEATH

12. DATE OF DEATH

13. TIME OF DEATH

14. SIGNATURE OF DECEASED

15. SIGNATURE OF WITNESS

16. SIGNATURE OF PHYSICIAN

17. SIGNATURE OF CORONER

18. SIGNATURE OF JURY

19. SIGNATURE OF JUDGE

20. SIGNATURE OF CLERK

21. SIGNATURE OF REGISTRAR

22. SIGNATURE OF VENDOR

23. SIGNATURE OF DISTRIBUTOR

24. SIGNATURE OF COLLECTOR

25. SIGNATURE OF AGENT

26. SIGNATURE OF ASSISTANT

27. SIGNATURE OF CLERK

28. SIGNATURE OF REGISTRAR

29. SIGNATURE OF VENDOR

30. SIGNATURE OF DISTRIBUTOR

31. SIGNATURE OF COLLECTOR

32. SIGNATURE OF AGENT

33. SIGNATURE OF ASSISTANT

34. SIGNATURE OF CLERK

35. SIGNATURE OF REGISTRAR

36. SIGNATURE OF VENDOR

37. SIGNATURE OF DISTRIBUTOR

38. SIGNATURE OF COLLECTOR

39. SIGNATURE OF AGENT

40. SIGNATURE OF ASSISTANT

41. SIGNATURE OF CLERK

42. SIGNATURE OF REGISTRAR

43. SIGNATURE OF VENDOR

44. SIGNATURE OF DISTRIBUTOR

BUREAU V. S.

DEC 6 1955

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**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed in 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11257

11241 **CERTIFICATE OF DEATH**

Reg. Dist. No. 290

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| <b>1. PLACE OF DEATH</b>   |  |  |  | <b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>  |  |   |  |
| COUNTY <u>Talbot</u>   |  | MARYLAND   |  | STATE <u>Md.</u>  |  | COUNTY <u>Talbot</u>  |  |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br><u>40</u> TOWN <u>Easton</u>  |  | LENGTH OF STAY (in this place)<br><u>3 days</u>  |  | CITY (If outside corporate limits, write RURAL and give nearest town)<br><u>40</u> TOWN <u>Easton</u> |  |   |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br><u>80</u> <u>Memorial</u>   |  |  |  | STREET ADDRESS (If rural give location)<br><u>206 Brooklets Cwe</u>                                   |  | <u>1</u>  |  |
| <b>3. NAME OF DECEASED</b><br>(Type or Print) (First) (Middle) (Last)<br><u>Merle B. Marshall</u>  |  |  |  | <b>4. DATE OF DEATH</b> (Month) (Day) (Year)<br><u>November 25 19 55</u>                              |  |   |  |
| <b>5. SEX</b><br><u>F</u>  |  | <b>6. COLOR OR RACE</b><br><u>W</u>  |  | <b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b><br><u>M</u>                                   |  | <b>8. DATE OF BIRTH</b><br><u>Feb. 27, 1902</u>                     |  |
| <b>9. AGE last birthday</b><br><u>53</u> yrs.  |  | <b>10. IF UNDER 1 YEAR</b><br>Months Days Hours Min.   |  | <b>11. BIRTHPLACE (State or foreign country)</b><br><u>Maryland</u>                                   |  | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>USA</u>                   |  |
| <b>13. FATHER'S NAME</b><br><u>Frank E Bullock</u>   |  |  |  | <b>14. MOTHER'S MAIDEN NAME</b><br><u>Anna Staylor</u>  |  |   |  |
| <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b><br>(Yes, no, or unk.) (If Yes, give war or dates of service)<br><u>Y</u>   |  | <b>16. SOCIAL SECURITY NO.</b>   |  | <b>17. INFORMANT'S ADDRESS</b><br><u>Mr Elbert Marshall</u>   |  |   |  |
| <b>18. MEDICAL CERTIFICATION</b>   |  |  |  | <b>19. INTERVAL BETWEEN ONSET AND DEATH</b>   |  |   |  |
| <b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b><br><u>332X</u> IMMEDIATE CAUSE (A) <u>Cerebral Infarct</u><br>ANTECEDENT CAUSE(S) DUE TO (B) <u>Thrombosis - basilar artery</u><br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) |  |  |  |   |  |   |  |
| <b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>   |  |  |  |   |  |   |  |
| <b>19a. DATE OF OPERATION</b><br><u>2</u>  |  | <b>19b. MAJOR FINDINGS OF OPERATION</b>  |  | <b>20. AUTOPSY?</b><br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  |   |  |
| <b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>  |  | <b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>  |  | <b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>                                   |  |   |  |
| <b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>   |  | <b>21e. INJURY OCCURRED</b><br>White Not white<br>M. et work <input type="checkbox"/> at work <input type="checkbox"/> |  | <b>21f. HOW DID INJURY OCCUR?</b>   |  |   |  |
| <b>22. I hereby certify that I attended the deceased from <u>11-22-1955</u>, to <u>11-25-1955</u>, that I last saw the deceased alive on <u>11-25-1955</u> and that death occurred at <u>8:30</u> P.M. from the causes and on the date stated above.</b>   |  |  |  |   |  |   |  |
| <b>SIGNATURE</b><br><u>[Signature]</u>   |  |  |  | <b>DATE SIGNED</b><br><u>28 Nov 1955</u>  |  |   |  |
| <b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>  |  | <b>DATE THEREOF</b><br><u>Nov 29 55</u>  |  | <b>NAME OF CEMETERY OR CREMATORY</b><br><u>Spring Hill</u>  |  | <b>LOCATION (City, town, or county) (State)</b><br><u>Easton Md</u> |  |
| <b>24. REC'D BY REGISTRAR</b><br>DATE <u>11-28-55</u>  |  | <b>REGISTRAR'S SIGNATURE</b><br><u>N.H. Neuring</u>  |  | <b>25. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>[Signature]</u>   |  | <b>ADDRESS</b><br><u>Easton Md</u>                                  |  |

CERTIFICATE OF DEATH

1. NAME OF DECEASED: [Faint text]

2. SEX: [Faint text]

3. AGE: [Faint text]

4. DATE OF BIRTH: [Faint text]

5. PLACE OF BIRTH: [Faint text]

6. OCCUPATION: [Faint text]

7. CAUSE OF DEATH: [Faint text]

8. PLACE OF DEATH: [Faint text]

9. TIME OF DEATH: [Faint text]

10. SIGNATURE OF PHYSICIAN: [Faint text]

11. SIGNATURE OF REGISTRAR: [Faint text]

BUREAU V. S.

NOV 20 1955

RECEIVED

*Handwritten notes and signatures at the bottom of the page.*

ENCLOSURE



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 11258  
11242 CERTIFICATE OF DEATH

Reg. Dist. No. 290

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH:  |  |  |  | 2. USUAL RESIDENCE (HOME) OF DECEASED:  |  |  |  |
| COUNTY <u>Salbot.</u>   |  | MARYLAND   |  | STATE <u>md.</u>  |  | COUNTY <u>Salbot.</u>                    |  |
| CITY (If outside corporate limits, write RURAL or and give nearest town)  |  | LENGTH OF STAY (in this place)   |  | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN |  |  |  |
| 40 TOWN <u>Easton.</u>  |  | 17 HRS.  |  | <u>Easton Wiltman</u> X   |  |  |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS   |  |  |  | STREET ADDRESS (If rural give location)                                       |  |  |  |
| 80 <u>Memorial Hospital</u>   |  |  |  | <u>1</u>  |  |  |  |
| 3. NAME OF DECEASED: (First) (Middle) (Last)  |  |  |  | 4. DATE (Month) (Day) (Year)  |  |  |  |
| <u>William Marshall Jr.</u>   |  |  |  | OF DEATH: <u>11</u> <u>6</u> <u>1905</u>                                      |  |  |  |
| 5. SEX:   |  | 6. COLOR OR RACE:  |  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):                             |  | 8. DATE OF BIRTH:                        |  |
| <u>Male.</u>  |  | <u>White</u>   |  | <u>Single.</u>  |  | <u>Memphs - 1948 7</u>                   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):  |  |  |  | 10B. KIND OF BUSINESS OR INDUSTRY:  |  | 9. AGE last birthday                     |  |
|   |  |  |  |   |  | yrs. Months Days Hours Min.              |  |
| 11. BIRTHPLACE (State or foreign country):  |  |  |  | 12. CITIZEN OF WHAT COUNTRY?  |  |  |  |
| <u>Wiltman</u>  |  |  |  | <u>USA.</u>   |  |  |  |
| 13. FATHER'S NAME:  |  |  |  | 14. MOTHER'S MAIDEN NAME:   |  |  |  |
| <u>William Marshall Sr.</u>   |  |  |  | <u>Marie Dyle.</u>  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)   |  |  |  | 16. SOCIAL SECURITY NO.   |  |  |  |
|   |  |  |  |   |  |  |  |
| 17. INFORMANT'S ADDRESS:  |  |  |  |   |  |  |  |
| <u>Mr. William Marshall Sr. Father</u>  |  |  |  |   |  |  |  |
| 18. MEDICAL CERTIFICATION   |  |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH         |  |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |  |  |  |   |  |  |  |
| 334X IMMEDIATE CAUSE  |  |  |  |   |  |  |  |
| (A) <u>Edema of brain</u>   |  |  |  |   |  |  |  |
| ANTECEDENT CAUSE (S)  |  |  |  |   |  |  |  |
| (B) <u>Fatty embolism of liver</u>  |  |  |  |   |  |  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.   |  |  |  |   |  |  |  |
| (C) <u>Pulmonary edema</u>  |  |  |  |   |  |  |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.  |  |  |  |   |  |  |  |
| 19A. DATE OF OPERATION:   |  |  |  | 19B. MAJOR FINDINGS OF OPERATION  |  |  |  |
| <u>2</u>  |  |  |  |   |  |  |  |
| 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |   |  |  |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)   |  | 21C. WHERE DID (City or town) (County) (State)                                |  | INJURY OCCUR?                            |  |
|   |  |  |  |   |  |  |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |  | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |  |  |
|   |  |  |  |   |  |  |  |
| 22. I hereby certify that I attended the deceased from ..... , 19....., to ..... , 19....., that I last saw the deceased alive on ..... , 19....., and that death occurred at <u>1:30AM</u> , from the causes and on the date stated above. |  |  |  |   |  |  |  |
| SIGNATURE <u>[Signature]</u>  |  |  |  | ADDRESS <u>Easton</u>   |  | DATE SIGNED <u>11-10-55</u>              |  |
|   |  |  |  | M. D.   |  |  |  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | DATE THEREOF   |  | NAME OF CEMETERY OR CREMATORY   |  | LOCATION (City, town, or county) (State) |  |
| <u>Burial</u>   |  | <u>Nov. 9, 1955</u>  |  | <u>Chinck Cemetery</u>  |  | <u>St. Michaels. Md</u>                  |  |
| DATE REC'D BY LOCAL REGISTRAR   |  | REGISTRAR'S SIGNATURE  |  | FUNERAL DIRECTOR  |  | ADDRESS                                  |  |
| <u>11-8-55</u>  |  | <u>N. H. Neerex</u>  |  | <u>St. Hamilton Harrison</u>  |  | <u>St. Michaels</u>                      |  |

BUREAU V. S.

NOV 15 1955

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## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 1243 CERTIFICATE OF DEATH

11259

Reg. Dist. No. 290

## 1. PLACE OF DEATH

COUNTY Talbot

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR end give nearest town)  
TOWN 40 EastonLENGTH OF STAY  
(In this place)  
8 yrs.HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

## 2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Md. COUNTY TalbotCITY (If outside corporate limits, write RURAL and give nearest town)  
OR TOWN 40 Easton.

STREET ADDRESS (If rural give location)

3. NAME OF DECEASED  
(Type or Print)

(First)

(Middle)

(Last)

Frank Ebaugh Mason

## 4. DATE OF DEATH

(Month)

(Day)

(Year)

11/20/55

19

## 5. SEX

M

## 6. COLOR OR RACE

W

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

Married

## 8. DATE OF BIRTH

Feb. 18, 1893

## 9. AGE last birthday

62 yrs.

## IF UNDER 1 YEAR

Months

Days

## IF UNDER 24 HRS.

Hours

Min.

## 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

M. D.

## 10b. KIND OF BUSINESS OR INDUSTRY

Practitioner

## 11. BIRTHPLACE (State or foreign country)

Easton, Md.

## 12. CITIZEN OF WHAT COUNTRY?

U. S.

## 13. FATHER'S NAME

Frank C. Mason

## 14. MOTHER'S MAIDEN NAME

Anna Ebaugh

## 15. WAS DECEASED EVER IN U. S. ARMED FORCES?

(Yes, no, or unk.) yes 1917-19 (If Yes, give year or dates of service)

## 16. SOCIAL SECURITY NO.

## 17. INFORMANT &amp; ADDRESS

Mrs. Frank E. Mason

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

157X IMMEDIATE CAUSE (A)

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

## II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## INTERVAL BETWEEN ONSET AND DEATH

6 mos.

## 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

## 21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)

## 21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

## 21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

## 21f. HOW DID INJURY OCCUR?

## 2D. AUTOPSY?

YES ☐ NO ☒22. I hereby certify that I attended the deceased from 1 Sept, 1955, to 20 Nov, 1955, that I last saw the deceased alive on 20 Nov, 1955, and that death occurred at 5:10 PM, from the causes and on the date stated above.

SIGNATURE

ADDRESS (Street, city, town, state)

DATE SIGNED

M. D.

## 23. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

## DATE THEREOF

Nov. 23, 55

## NAME OF CEMETERY OR CREMATORY

Spring Hill

## LOCATION (City, town, or county)

Easton, Md.

(State)

## 24. REC'D BY REGISTRAR

## REGISTRAR'S SIGNATURE

## 25. FUNERAL DIRECTOR'S SIGNATURE

## ADDRESS

DATE

11-23/55N. H. NeerWilliam E. EbaughEaston

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled in by the funeral director, the third copy of this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11260

## 11244 CERTIFICATE OF DEATH

Reg. Dist. No. 290...

|   |   |   |                      |
|---|---|---|----------------------|
| 1. PLACE OF DEATH:  |   | 2. USUAL RESIDENCE (HOME) OF DECEASED:  |                      |
| COUNTY <b>Talbot</b>  | MARYLAND                                      | STATE <b>Md.</b>  | COUNTY <b>Talbot</b> |
| CITY (If outside corporate limits, write RURAL OR and give nearest town)<br><b>40 TOWN Easton</b>     | LENGTH OF STAY (in this place)<br><b>life</b> | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>40 Easton</b>  |                      |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br><b>10</b>  |   | STREET ADDRESS (If rural give location)<br><b>16 Biery St.</b>  |                      |
| 3. NAME OF DECEASED:  |   | 4. DATE (Month) (Day) (Year) OF DEATH:  |                      |
| (First) (Middle) (Last)<br><b>Bertha Patrick McCormick</b>  |   | <b>Nov. 13, 1955</b>  |                      |
| 5. SEX:   | 6. COLOR OR RACE:                             | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):   | 8. DATE OF BIRTH:    |
| <b>Female</b>   | <b>white</b>                                  | <b>married</b>  | <b>June 12, 1895</b> |
| 9. AGE last birthday  |   | 10. IF UNDER 1 YEAR   |                      |
| <b>60 yrs.</b>  |   | <b>Months Days Hours Min.</b>   |                      |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):          |   | 10B. KIND OF BUSINESS OR INDUSTRY:  |                      |
| <b>housewife -</b>  |   | <b>Caroline Co.</b>   |                      |
| 11. BIRTHPLACE (State or foreign country):  |   | 12. CITIZEN OF WHAT COUNTRY?  |                      |
| <b>U. S.</b>  |   | <b>U. S.</b>  |                      |
| 13. FATHER'S NAME:  |   | 14. MOTHER'S MAIDEN NAME:   |                      |
| <b>Dave Patrick</b>   |   | <b>Mary Cole</b>  |                      |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) |   | 16. SOCIAL SECURITY NO.   |                      |
| <b>7</b>  |   | <b>220-01-2198</b>  |                      |
| 17. INFORMANT & ADDRESS:  |   | 18. MEDICAL CERTIFICATION   |                      |
| <b>A. Tait McCormick Easton, Md.</b>  |   | I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH<br><b>163X</b><br>IMMEDIATE CAUSE (A) <b>Carcinoma of lung</b><br>DUE TO<br>ANTECEDENT CAUSE (S) (B) <b>metastasis to spine</b><br>DUE TO<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.<br>(C)<br>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. |                      |
| 19A. DATE OF OPERATION:   |   | 19B. MAJOR FINDINGS OF OPERATION  |                      |
| <b>July 9, 1955-3</b>   |   | <b>Ca of lung &amp; involvement of mediastinal glands</b>   |                      |
| 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                      |   | 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                      |
| 21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY                                |   | 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?  |                      |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |   | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |                      |
| 21F. HOW DID INJURY OCCUR?  |   | 22. I hereby certify that I attended the deceased from <b>7/11</b> , 1955, to <b>11/13</b> , 1955, that I last saw the deceased alive on <b>11/12</b> , 1955, and that death occurred at <b>2:40</b> M, from the causes and on the date stated above.   |                      |
| SIGNATURE <b>B. Cox</b>   |   | ADDRESS <b>Easton Md</b> DATE SIGNED <b>11/13/55</b>  |                      |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)  |   | DATE THEREOF  |                      |
| <b>burial</b>   |   | <b>Nov. 16, 1955</b>  |                      |
| NAME OF CEMETERY OR CREMATORY   |   | LOCATION (City, town, or county) (State)  |                      |
| <b>Greenmount Cemetery</b>  |   | <b>Hillsboro, Queen Anne Co. Md.</b>  |                      |
| DATE REC'D BY LOCAL REGISTRAR   |   | REGISTRAR'S SIGNATURE   |                      |
| <b>11-14-55</b>   |   | <b>N. H. Newnam</b>   |                      |
| 24. FUNERAL DIRECTOR  |   | ADDRESS   |                      |
| <b>Maurice E. Newnam &amp; Son</b>  |   | <b>Easton, Md.</b>  |                      |

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NOV 17 1955

BUREAU Y. S.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11261

## 11245 CERTIFICATE OF DEATH

Reg. Dist. No. 290

|   |                   |  |                                    |   |                 |  |       |
|---|-------------------|--|------------------------------------|---|-----------------|--|-------|
| 1. PLACE OF DEATH:  |                   |  |                                    | 2. USUAL RESIDENCE (HOME) OF DECEASED:  |                 |  |       |
| COUNTY <u>Talbot</u>  |                   | MARYLAND   |                                    | STATE <u>md</u>   |                 | COUNTY <u>Talbot</u>   |       |
| CITY (If outside corporate limits, write RURAL OR give nearest town)  |                   | LENGTH OF STAY (in this place)   |                                    | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN |                 |  |       |
| <u>40</u> TOWN <u>Easton</u>  |                   | <u>1 mo - 1 day</u>  |                                    | <u>Bozman</u>   |                 |  |       |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS   |                   |  |                                    | STREET ADDRESS (If rural give location)                                       |                 |  |       |
| <u>80</u> <u>Memorial Hospital</u>  |                   |  |                                    | <u>Pine Point Farm</u>  |                 |  |       |
| 3. NAME OF DECEASED: (First) (Middle) (Last)  |                   |  |                                    | 4. DATE (Month) (Day) (Year) OF DEATH:  |                 |  |       |
| <u>William</u> <u>S</u> <u>Milan</u>  |                   |  |                                    | <u>November 5 1955</u>  |                 |  |       |
| 5. SEX:   | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):  | 8. DATE OF BIRTH:                  | 9. AGE last birthday  | IF UNDER 1 YEAR | IF UNDER 24 HRS.   |       |
| <u>M</u>  | <u>W</u>          |  | <u>July 6 1876</u>                 | <u>79</u> yrs.  | Months          | Days   | Hours |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):  |                   |  | 10B. KIND OF BUSINESS OR INDUSTRY: | 11. BIRTHPLACE (State or foreign country):                                    |                 | 12. CITIZEN OF WHAT COUNTRY?   |       |
|   |                   |  |                                    | <u>New York</u>   |                 | <u>USA</u>   |       |
| 13. FATHER'S NAME:  |                   |  |                                    | 14. MOTHER'S MAIDEN NAME:   |                 |  |       |
| <u>Mr. Michael Milan</u>  |                   |  |                                    | <u>Unknown</u>  |                 |  |       |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)  |                   | 16. SOCIAL SECURITY NO.  |                                    | 17. INFORMANT & ADDRESS:  |                 |  |       |
|   |                   |  |                                    | <u>Mrs Evelyn Milan (wife)</u>  |                 |  |       |
| 18. MEDICAL CERTIFICATION   |                   |  |                                    |   |                 |  |       |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |                   |  |                                    |   |                 | INTERVAL BETWEEN ONSET AND DEATH   |       |
| IMMEDIATE CAUSE   |                   |  |                                    |   |                 |  |       |
| <u>332X</u>   |                   |  |                                    |   |                 |  |       |
| ANTECEDENT CAUSE (S)  |                   |  |                                    |   |                 |  |       |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.   |                   |  |                                    |   |                 |  |       |
| <u>260X</u>   |                   |  |                                    |   |                 |  |       |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.  |                   |  |                                    |   |                 |  |       |
| <u>diabetes mellitus</u>  |                   |  |                                    |   |                 | <u>Years</u>   |       |
| 19A. DATE OF OPERATION:   |                   | 19B. MAJOR FINDINGS OF OPERATION   |                                    |   |                 | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |       |
| <u>0</u>  |                   |  |                                    |   |                 |  |       |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                   | 21B. PLACE (Home, farm, factory, street, office bldg., etc.)   |                                    | 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?                  |                 |  |       |
|   |                   |  |                                    |   |                 |  |       |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |                   | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |                                    | 21F. HOW DID INJURY OCCUR?  |                 |  |       |
|   |                   |  |                                    |   |                 |  |       |
| 22. I hereby certify that I attended the deceased from <u>5-29-</u> , 19 <u>55</u> , to <u>11-5-</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11-5-</u> , 19 <u>55</u> , and that death occurred at <u>5:20 PM</u> , from the causes and on the date stated above. |                   |  |                                    |   |                 |  |       |
| SIGNATURE   |                   | ADDRESS  |                                    | DATE SIGNED   |                 |  |       |
| <u>Donald A. Bartley</u>  |                   | <u>Easton Md.</u>  |                                    | <u>11-5-55</u>  |                 |  |       |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)  |                   | DATE THEREOF   |                                    | NAME OF CEMETERY OR CREMATORY   |                 | LOCATION (City, town, or county) (State)   |       |
| <u>Burial</u>   |                   | <u>Nov. 8, 1955</u>  |                                    | <u>Evergreen Cemetery Brooklyn</u>  |                 | <u>New York</u>  |       |
| DATE REC'D BY LOCAL REGISTRAR   |                   | REGISTRAR'S SIGNATURE  |                                    | 24. FUNERAL DIRECTOR  |                 | ADDRESS  |       |
| <u>11/6/55</u>  |                   | <u>N. H. Nevers</u>  |                                    | <u>St. Ambrose Harrison, St. Michael's</u>                                    |                 |  |       |



RECEIVED

NOV 15 1955

BUREAU V. S.

## INSTRUCTIONS

**1**  
**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed **within 24 hours** after death. The bottom copy may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11246 **CERTIFICATE OF DEATH**

11262

Reg. Dist. No. 290

|   |                                      |   |  |  |   |  |  |
|---|--------------------------------------|---|--|--|---|--|--|
| <b>1. PLACE OF DEATH</b>  |                                      |   |  | <b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>   |   |  |  |
| COUNTY <u>Talbot</u>  |                                      | MARYLAND  |  | STATE <u>MD</u>  |   | COUNTY <u>Talbot</u>   |  |
| CITY (If outside corporate limits, write RURAL OR end give nearest town)<br>TOWN <u>Easton</u>  |                                      | LENGTH OF STAY (in this place)<br><u>9 yrs</u>  |  | CITY (If outside corporate limits, write RURAL and give nearest town)<br>TOWN <u>410 North St.</u> |   | <u>40</u>  |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br><u>00</u>  |                                      |   |  | STREET ADDRESS (If rural give location)<br><u>Easton Md.</u>                                       |   | <u>1</u>   |  |
| <b>3. NAME OF DECEASED</b><br>(Type or Print) <u>Howard</u> (First) <u>Miles</u> (Middle) <u>Miles</u> (Last)   |                                      |   |  | <b>4. DATE OF DEATH</b> (Month) <u>Nov.</u> (Day) <u>22</u> (Year) <u>1955</u>                     |   |  |  |
| <b>5. SEX</b><br><u>M.</u>  | <b>6. COLOR OR RACE</b><br><u>W.</u> | <b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b><br><u>MARRIED</u>   | <b>8. DATE OF BIRTH</b><br><u>Aug 22, 1875</u> |  | <b>9. AGE last birthday</b><br><u>80</u> yrs. | <b>IF UNDER 1 YEAR</b><br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>Carpenter</u>  |                                      | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><u>Carpentry</u>  |  | <b>11. BIRTHPLACE</b> (State or foreign country)<br><u>Md.</u>                                     |   | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>U.S.</u>                                       |  |
| <b>13. FATHER'S NAME</b><br><u>Paulson J. Miles</u>   |                                      |   |  | <b>14. MOTHER'S MAIDEN NAME</b><br><u>Sallie E. Hall</u>   |   |  |  |
| <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no or unk.) <u>No</u> (If Yes, give war or dates of service)  |                                      | <b>16. SOCIAL SECURITY NO.</b>  |  | <b>17. INFORMANT &amp; ADDRESS</b><br><u>Mary Ford</u>   |   | <u>Frederick Md.</u>   |  |
| <b>18. MEDICAL CERTIFICATION</b>  |                                      |   |  |  |   |  |  |
| <b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b><br><u>420.0</u> IMMEDIATE CAUSE (A) <u>MYOCARDIAL INFARCTION</u>  |                                      |   |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>Instant.</u>                                      |  |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>ARTERIOSCLEROTIC Heart Disease</u>  |                                      |   |  |  |   | <u>10 years.</u>   |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C)   |                                      |   |  |  |   |  |  |
| <b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>   |                                      |   |  |  |   |  |  |
| <b>19a. DATE OF OPERATION</b>   |                                      | <b>19b. MAJOR FINDINGS OF OPERATION</b>   |  |  |   |  |  |
|   |                                      |   |  |  |   |  |  |
| <b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>   |                                      | <b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>   |  | <b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)                                |   | <b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| <b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)  |                                      | <b>21e. INJURY OCCURRED</b> White <input type="checkbox"/> Not white <input type="checkbox"/> M. <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |  | <b>21f. HOW DID INJURY OCCUR?</b>  |   |  |  |
|   |                                      |   |  |  |   |  |  |
| <b>22. I hereby certify that I attended the deceased from</b> <u>Apr.</u> , 19 <u>49</u> , to <u>Oct.</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Oct. 15</u> , 19 <u>55</u> , and that death occurred at <u>9:45 A.</u> M, from the causes and on the date stated above. |                                      |   |  |  |   |  |  |
| <b>SIGNATURE</b><br><u>Sheena J.</u> M.D.   |                                      |   |  | <b>ADDRESS</b> (Street, city, town, state)<br><u>Easton, Md.</u>                                   |   | <b>DATE SIGNED</b><br><u>11/23/55</u>  |  |
| <b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>   |                                      | <b>DATE THEREOF</b><br><u>Nov 26 55</u>   |  | <b>NAME OF CEMETERY OR CREMATORY</b><br><u>St. Andrews</u>   |   | <b>LOCATION</b> (City, town, or county) (State)<br><u>Princess Anne Md</u>               |  |
| <b>24. REC'D BY REGISTRAR</b>   |                                      | <b>REGISTRAR'S SIGNATURE</b><br><u>N.A. Newries</u>   |  | <b>25. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>Neven Wilson</u>                                     |   | <b>ADDRESS</b><br><u>Princess Anne, Md.</u>  |  |
| <b>DATE</b> <u>11-25-55</u>   |                                      |   |  |  |   |  |  |



**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**2** **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11247

## CERTIFICATE OF DEATH

11263

Reg. Dist. No. 290

Items 12, 11 Film G189 12-5-55 et

|  |                         |   |                         |   |                        |   |            |
|--|-------------------------|---|-------------------------|---|------------------------|---|------------|
| <b>1. PLACE OF DEATH</b>   |                         |   |                         | <b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>                          |                        |   |            |
| COUNTY <i>Talbot</i>   |                         | MARYLAND  |                         | STATE <i>md.</i>  |                        | COUNTY <i>Talbot</i>  |            |
| CITY (If outside corporate limits, write RURAL OR and give nearest town)   |                         | LENGTH OF STAY (in this place)  |                         | CITY (If outside corporate limits, write RURAL and give nearest town) |                        |   |            |
| <i>40</i> TOWN <i>Easton</i>   |                         | <i>30 days</i>  |                         | <i>40</i> TOWN <i>Easton</i>  |                        |   |            |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS  |                         |   |                         | STREET ADDRESS (If rural give location)                               |                        |   |            |
| <i>80</i> <i>Memorial Hospital</i>   |                         |   |                         | <i>St. Michaels Rd.</i>   |                        | <i>1</i>  |            |
| <b>3. NAME OF DECEASED</b> (First) (Middle) (Last)   |                         |   |                         | <b>4. DATE OF DEATH</b> (Month) (Day) (Year)                          |                        |   |            |
| <i>M Charles S. Morgan</i>   |                         |   |                         | <i>Nov. 24 19 55</i>  |                        |   |            |
| <b>5. SEX</b>  | <b>6. COLOR OR RACE</b> | <b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>   | <b>8. DATE OF BIRTH</b> | <b>9. AGE last birthday</b>   | <b>IF UNDER 1 YEAR</b> | <b>IF UNDER 24 HRS.</b>   |            |
| <i>M</i>   | <i>White</i>            | <i>widowed</i>  | <i>Sept. 28 1874</i>    | <i>80</i> yrs.  | Months                 | Days  | Hours Min. |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)   |                         | <b>10b. KIND OF BUSINESS OR INDUSTRY</b>  |                         | <b>11. BIRTHPLACE</b> (State or foreign country)                      |                        | <b>12. CITIZEN OF WHAT COUNTRY?</b>   |            |
| <i>laborer</i>   |                         | <i>Machine Shop</i>   |                         | <i>Maryland</i>   |                        | <i>U. S.</i>  |            |
| <b>13. FATHER'S NAME</b>   |                         |   |                         | <b>14. MOTHER'S MAIDEN NAME</b>                                       |                        |   |            |
| <i>Chas Morgan</i>   |                         |   |                         | <i>Ros Marion</i>   |                        |   |            |
| <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)   |                         | <b>16. SOCIAL SECURITY NO.</b>  |                         | <b>17. INFORMANT &amp; ADDRESS</b>                                    |                        |   |            |
| <i>40</i> (If Yes, give war or dates of service)   |                         |   |                         | <i>Charles W. Morgan Easton</i>                                       |                        |   |            |
| <b>18. MEDICAL CERTIFICATION</b>   |                         |   |                         |   |                        |   |            |
| <b>1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>   |                         |   |                         |   |                        |   |            |
| <i>420.0</i> IMMEDIATE CAUSE (A) <i>Heart failure</i>  |                         |   |                         |   |                        |   |            |
| ANTECEDENT CAUSE(S) DUE TO (B) <i>arteriosclerotic heart disease</i>   |                         |   |                         |   |                        |   |            |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <i>STATING UNDERLYING CAUSE LAST.</i>  |                         |   |                         |   |                        |   |            |
| <b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>  |                         |   |                         |   |                        |   |            |
| <b>19a. DATE OF OPERATION</b>  |                         |   |                         | <b>19b. MAJOR FINDINGS OF OPERATION</b>                               |                        |   |            |
| <i>2</i>   |                         |   |                         |   |                        |   |            |
| <b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>  |                         | <b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>                                 |                         | <b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)   |                        | <b>20. AUTOPSY?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |            |
|  |                         |   |                         |   |                        |   |            |
| <b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)   |                         | <b>21a. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |                         | <b>21f. HOW DID INJURY OCCUR?</b>                                     |                        |   |            |
|  |                         | <i>M.</i>   |                         |   |                        |   |            |
| <b>22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at....., 11:54 AM, from the causes and on the date stated above.</b> |                         |   |                         |   |                        |   |            |
| <b>SIGNATURE</b>   |                         |   |                         | <b>ADDRESS</b> (Street, city, town, state)                            |                        | <b>DATE SIGNED</b>  |            |
| <i>Chas Morgan</i>   |                         |   |                         | <i>Easton</i>   |                        | <i>25 Nov 55</i>  |            |
| <b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>  |                         |   |                         | <b>DATE THEREOF</b>   |                        | <b>NAME OF CEMETERY OR CREMATORY</b>  |            |
| <i>Nov. 26 55</i>  |                         |   |                         | <i>Spring Hill</i>  |                        | <i>Easton</i>   |            |
| <b>24. REC'D BY REGISTRAR</b>  |                         | <b>REGISTRAR'S SIGNATURE</b>  |                         | <b>25. FUNERAL DIRECTOR'S SIGNATURE</b>                               |                        | <b>ADDRESS</b>  |            |
| <i>11-25-55</i>  |                         | <i>M. H. Newell</i>   |                         | <i>Charles W. Morgan</i>  |                        | <i>Easton</i>   |            |

CERTIFICATE OF DEATH

NOV 30 1955

1. Name of deceased (Print or write full name)

2. Sex (Male or Female)

3. Age (Years and months)

4. Date of birth (Month, day, year)

5. Place of birth (City, State, Country)

6. Usual residence (Street, City, State, Country)

7. Cause of death (Immediate cause)

8. Cause of death (Underlying cause)

9. Cause of death (Contributing cause)

10. Date of death (Month, day, year)

11. Place of death (City, State, Country)

12. Signature of physician (Print name)

13. Signature of physician (Print name)

14. Signature of physician (Print name)

15. Signature of physician (Print name)

16. Signature of physician (Print name)

17. Signature of physician (Print name)

18. Signature of physician (Print name)

19. Signature of physician (Print name)

20. Signature of physician (Print name)

21. Signature of physician (Print name)

22. Signature of physician (Print name)

23. Signature of physician (Print name)

24. Signature of physician (Print name)

25. Signature of physician (Print name)

26. Signature of physician (Print name)

27. Signature of physician (Print name)

28. Signature of physician (Print name)

29. Signature of physician (Print name)

BUREAU V. S.

NOV 30 1955

RECEIVED

NOV 30 1955

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11255

11258

## CERTIFICATE OF DEATH

Reg. Dist. No. 291

|  |                                |   |                                     |   |                 |   |  |
|--|--------------------------------|---|-------------------------------------|---|-----------------|---|--|
| 1. PLACE OF DEATH:   |                                |   |                                     | 2. USUAL RESIDENCE (HOME) OF DECEASED:  |                 |   |  |
| COUNTY <i>Talbot</i>   |                                | MARYLAND  |                                     | STATE <i>Maryland</i>   |                 | COUNTY <i>Talbot</i>  |  |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br><i>Wittman</i>  |                                | LENGTH OF STAY (in this place)<br><i>8 years</i>  |                                     | CITY (If outside corporate limits, write RURAL and give nearest town)<br><i>Wittman</i> |                 |   |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br><i>00</i>   |                                |   |                                     | STREET ADDRESS (If rural give location)<br><i>1</i>                                     |                 |   |  |
| 3. NAME OF DECEASED: (Type or Print) <i>Saura M. Sheeler</i>   |                                |   |                                     | 4. DATE (Month) (Day) (Year) OF DEATH: <i>Nov. 26 1953</i>                              |                 |   |  |
| 5. SEX: <i>Female</i>  | 6. COLOR OR RACE: <i>White</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Single</i>   | 8. DATE OF BIRTH: <i>FEB-8-1872</i> | 9. AGE last birthday: <i>83</i> yrs.  | IF UNDER 1 YEAR | IF UNDER 24 HRS.  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):   |                                |   |                                     | 10B. KIND OF BUSINESS OR INDUSTRY:  |                 | 11. BIRTHPLACE (State or foreign country): <i>Reading Penna</i> |  |
| 13. FATHER'S NAME: <i>Jasper Sheeler</i>   |                                |   |                                     | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>  |                 |   |  |
| 14. MOTHER'S MAIDEN NAME: <i>Mary Bertolotti</i>   |                                |   |                                     | 17. INFORMANT & ADDRESS: <i>Mrs. W. L. Sheeler</i>                                      |                 |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>   |                                |   |                                     | 16. SOCIAL SECURITY NO. <i>none</i>   |                 |   |  |
| 19. MEDICAL CERTIFICATION  |                                |   |                                     | INTERVAL BETWEEN ONSET AND DEATH  |                 |   |  |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |                                |   |                                     |   |                 |   |  |
| IMMEDIATE CAUSE<br><i>4343</i>   |                                |   |                                     | <i>Calculus heart and coronary</i>  |                 |   |  |
| ANTECEDENT CAUSE (S)   |                                |   |                                     | DUE TO  |                 |   |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.  |                                |   |                                     | DUE TO  |                 |   |  |
| (C)  |                                |   |                                     |   |                 |   |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Support 3 months after</i>   |                                |   |                                     |   |                 |   |  |
| 19A. DATE OF OPERATION: <i>0</i>   |                                |   |                                     | 19B. MAJOR FINDINGS OF OPERATION  |                 |   |  |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                |   |                                     |   |                 |   |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)  |                                     | 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?                            |                 |   |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |                                | 21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |                                     | 21F. HOW DID INJURY OCCUR?  |                 |   |  |
| 22. I hereby certify that I attended the deceased from <i>May</i> , 1955, to <i>Nov 23</i> , 1955, that I last saw the deceased alive on <i>Nov 23</i> , 1955, and that death occurred at <i>HA</i> M, from the causes and on the date stated above. |                                |   |                                     |   |                 |   |  |
| SIGNATURE <i>Wm. Reese</i>   |                                |   |                                     | ADDRESS <i>Talbot</i>   |                 | DATE SIGNED <i>Nov 28 1955</i>                                  |  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>   |                                | DATE THEREOF <i>11/29/55</i>  |                                     | NAME OF CEMETERY OR CREMATORY <i>Charles Evans Cem.</i>                                 |                 | LOCATION (City, town, or county) (State) <i>Reading Pa</i>      |  |
| DATE REC'D BY LOCAL REGISTRAR <i>11/28/55</i>  |                                | REGISTRAR'S SIGNATURE <i>H. A. Heer</i>   |                                     | 24. FUNERAL DIRECTOR <i>M. E. Newman &amp; Son</i>                                      |                 | ADDRESS <i>Easton Md</i>  |  |



RECEIVED

DEC 6 1955

BUREAU V. S.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11248 CERTIFICATE OF DEATH

Reg. Dist. No. 11266 298...

|   |                   |  |                    |   |                             |  |  |
|---|-------------------|--|--------------------|---|-----------------------------|--|--|
| 1. PLACE OF DEATH:  |                   |  |                    | 2. USUAL RESIDENCE (HOME) OF DECEASED:  |                             |  |  |
| COUNTY <i>Talbot</i>  |                   | MARYLAND   |                    | STATE <i>Maryland</i> COUNTY <i>Talbot</i>                                    |                             |  |  |
| CITY (If outside corporate limits, write RURAL OR and give nearest town)  |                   | LENGTH OF STAY (in this place)   |                    | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN |                             |  |  |
| 40 TOWN <i>Easton</i>   |                   | 1 wk.  |                    | 40 TOWN <i>Easton</i>   |                             |  |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS   |                   |  |                    | STREET ADDRESS (If rural give location)                                       |                             |  |  |
| 80 <i>Easton Memorial Hospital</i>  |                   |  |                    | 206 <i>Idlewild Ave.</i>  |                             |  |  |
| 3. NAME OF DECEASED: (First) (Middle) (Last)  |                   |  |                    | 4. DATE (Month) (Day) (Year) OF DEATH:  |                             |  |  |
| <i>James H. Laughter</i>  |                   |  |                    | <i>11 17 1955</i>   |                             |  |  |
| 5. SEX:   | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):  | 8. DATE OF BIRTH:  | 9. AGE last birthday  | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.  |  |
| <i>M</i>  | <i>W</i>          |  | <i>Jan 30 1886</i> | <i>69</i> yrs.  |                             |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):  |                   | 10B. KIND OF BUSINESS OR INDUSTRY:   |                    | 11. BIRTHPLACE (State or foreign country):                                    |                             | 12. CITIZEN OF WHAT COUNTRY?   |  |
| <i>Carpenter</i>  |                   |  |                    | <i>Maryland</i>   |                             | <i>U.S.A.</i>  |  |
| 13. FATHER'S NAME:  |                   |  |                    | 14. MOTHER'S MAIDEN NAME:   |                             |  |  |
| <i>Theodore H. Laughter</i>   |                   |  |                    | <i>Mary Charlotte Callahan</i>  |                             |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)   |                   |  |                    | 17. INFORMANT & ADDRESS:  |                             |  |  |
|   |                   |  |                    | <i>Mrs. Agnes Claggett (daughter)</i>   |                             |  |  |
| 18. MEDICAL CERTIFICATION   |                   |  |                    | INTERVAL BETWEEN ONSET AND DEATH  |                             |  |  |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |                   |  |                    |   |                             |  |  |
| 420.1 IMMEDIATE CAUSE   |                   |  |                    |   |                             |  |  |
| ANTECEDENT CAUSE (S)  |                   |  |                    |   |                             |  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.   |                   |  |                    |   |                             |  |  |
| (A) DUE TO <i>Myocardial Infarction</i>   |                   |  |                    |   |                             |  |  |
| (B) DUE TO <i>Coronary occlusion</i>  |                   |  |                    |   |                             |  |  |
| (C) DUE TO  |                   |  |                    |   |                             |  |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.  |                   |  |                    |   |                             |  |  |
| 19A. DATE OF OPERATION:   |                   |  |                    | 19B. MAJOR FINDINGS OF OPERATION  |                             |  |  |
| <i>2</i>  |                   |  |                    |   |                             |  |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                   | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)   |                    | 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?                  |                             | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |                   | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |                    | 21F. HOW DID INJURY OCCUR?  |                             |  |  |
| M.  |                   |  |                    |   |                             |  |  |
| 22. I hereby certify that I attended the deceased from ....., 19....., to ....., 19....., that I last saw the deceased alive on ....., 19....., and that death occurred at <i>1:40 P.M.</i> from the causes and on the date stated above. |                   |  |                    |   |                             |  |  |
| SIGNATURE <i>[Signature]</i>  |                   |  |                    | DATE SIGNED <i>27 Nov 1955</i>  |                             |  |  |
| M.D. <i>Coaston</i>   |                   |  |                    |   |                             |  |  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)  |                   | DATE THEREOF   |                    | NAME OF CEMETERY OR CREMATORY   |                             | LOCATION (City, town, or county) (State)   |  |
| <i>burial</i>   |                   | <i>Nov. 21, 55</i>   |                    | <i>Spring Hill</i>  |                             | <i>Easton</i>  |  |
| DATE REC'D BY LOCAL REGISTRAR   |                   | REGISTRAR'S SIGNATURE  |                    | 24. FUNERAL DIRECTOR  |                             | ADDRESS  |  |
| <i>11-18-55</i>   |                   | <i>H. H. Neenan</i>  |                    | <i>[Signature]</i>  |                             | <i>Easton</i>  |  |

BUREAU V. S.

NOV 29 1955

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**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**2** **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11249

## CERTIFICATE OF DEATH

11268

Reg. Dist. No. 290

|   |                                  |   |   |  |                                |   |                                |
|---|----------------------------------|---|---|--|--------------------------------|---|--------------------------------|
| <b>1. PLACE OF DEATH</b>  |                                  |   |   | <b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>   |                                |   |                                |
| COUNTY <i>Talbot</i>  |                                  | MARYLAND  |   | STATE <i>Maryland</i>  |                                | COUNTY <i>Caroline</i>  |                                |
| CITY (If outside corporate limits, write RURAL OR and give nearest town)<br>40 TOWN <i>EASTON</i>   |                                  | LENGTH OF STAY (in this place)<br>2 days  |   | CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR TOWN <i>Greensboro</i> |                                | 05X-2   |                                |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br>80 <i>Memorial Hosp.</i>   |                                  |   |   | STREET ADDRESS (If rural give location)  |                                |   |                                |
| <b>3. NAME OF DECEASED</b><br>(Type or Print) <i>Mary</i> (First) <i>Thomas</i> (Last)  |                                  |   |   | <b>4. DATE OF DEATH</b> (Month) <i>11</i> (Day) <i>17</i> (Year) <i>1955</i>                       |                                |   |                                |
| 5. SEX<br><i>F</i>  | 6. COLOR OR RACE<br><i>white</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>MARRIED</i>   | 8. DATE OF BIRTH<br><i>Feb. 5, 1895</i> | 9. AGE last birthday<br><i>60</i> yrs.   | IF UNDER 1 YEAR<br>Months Days |   | IF UNDER 24 HRS.<br>Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Collar Seller</i>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><i>Shirt Factory</i>   |   | 11. BIRTHPLACE (State or foreign country)<br><i>Delaware</i>                                       |                                | 12. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>                          |                                |
| 13. FATHER'S NAME<br><i>Bert Mitchell</i>   |                                  |   |   | 14. MOTHER'S MAIDEN NAME<br><i>Belle Darling</i>   |                                |   |                                |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>g</i>  |                                  | 16. SOCIAL SECURITY NO.   |   | 17. INFORMANT & ADDRESS<br><i>M. Jacob Thomas</i>  |                                |   |                                |
| <b>18. MEDICAL CERTIFICATION</b>  |                                  |   |   | INTERVAL BETWEEN ONSET AND DEATH   |                                |   |                                |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |                                  |   |   | <i>3 days</i>  |                                |   |                                |
| 331X IMMEDIATE CAUSE (A) <i>Cerebral hemorrhage &amp;</i>   |                                  |   |   |  |                                |   |                                |
| ANTECEDENT CAUSE(S) DUE TO (B) <i>rel. hemiplegia &amp; aphasia</i>   |                                  |   |   |  |                                |   |                                |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <i>STATING UNDERLYING CAUSE LAST.</i>   |                                  |   |   |  |                                |   |                                |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.  |                                  |   |   |  |                                |   |                                |
| 19a. DATE OF OPERATION  |                                  | 19b. MAJOR FINDINGS OF OPERATION  |   | 20. AUTOPSY  |                                | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)  |   | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)                                       |                                |   |                                |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour)   |                                  | 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. at work <input type="checkbox"/> at work <input type="checkbox"/> |   | 21f. HOW DID INJURY OCCUR?   |                                |   |                                |
| 22. I hereby certify that I attended the deceased from <i>12:00</i> <i>1955</i> , to <i>12:00</i> , <i>1955</i> , that I last saw the deceased alive on <i>12:00</i> , <i>1955</i> , and that death occurred at <i>8:00</i> P.M., from the causes and on the date stated above. |                                  |   |   |  |                                |   |                                |
| SIGNATURE <i>Mountain</i> M.D.  |                                  |   |   | ADDRESS (Street, city, town, state) <i>Carroll Maryland</i>  |                                | DATE SIGNED <i>25 Nov 55</i>  |                                |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>   |                                  | DATE THEREOF<br><i>11/20/55</i>   |   | NAME OF CEMETERY OR CREMATORY<br><i>Greensboro</i>   |                                | LOCATION (City, town, or county) (State)<br><i>Greensboro, Md.</i>  |                                |
| 24. REC'D BY REGISTRAR<br>DATE <i>11-18-55</i>  |                                  | REGISTRAR'S SIGNATURE<br><i>N.H. Neerue</i>   |   | 25. FUNERAL DIRECTOR'S SIGNATURE<br><i>J.E. Boulaie</i>  |                                | ADDRESS<br><i>Greensboro, Md.</i>                                   |                                |



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11259

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

11269  
Reg. Dist.

No. 291

|  |                               |   |                                  |   |  |   |  |
|--|-------------------------------|---|----------------------------------|---|--|---|--|
| <b>1. PLACE OF DEATH:</b>  |                               |   |                                  | <b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b>   |  |   |  |
| COUNTY <u>TALBOT</u>   |                               | MARYLAND  |                                  | STATE <u>Md</u>   |  | COUNTY <u>TALBOT</u>  |  |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Royal Oak</u>  |                               | LENGTH OF STAY (in this place)  |                                  | CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Royal Oak</u>   |  |   |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS  |                               |   |                                  | STREET ADDRESS (If rural, give location)  |  |   |  |
| 3. NAME OF DECEASED: (Type or Print) <u>Sullivan THOMAS</u>  |                               |   |                                  | 4. DATE OF DEATH (Month) (Day) (Year) <u>11 12 1955</u>   |  |   |  |
| 5. SEX: <u>male</u>  | 6. COLOR OR RACE: <u>Col.</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>  | 8. DATE OF BIRTH: <u>7/10/87</u> | 9. AGE last birthday: <u>68</u> yrs.  |  | IF UNDER 1 YEAR: Months Days Hours Min.                       |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>hobby</u>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY: <u>Gardner</u>   |                                  | 11. BIRTHPLACE (State or foreign country): <u>MD.</u>   |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>                    |  |
| 13. FATHER'S NAME: <u>Joseph Oliver</u>  |                               |   |                                  | 14. MOTHER'S MAIDEN NAME: <u>Ella Thomas</u>  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u>  |                               | 16. SOCIAL SECURITY No.: <u>(If Yes, give war or dates of service)</u>  |                                  | 17. INFORMANT & ADDRESS: <u>W. McKinley Thomas New York</u>   |  |   |  |
| <b>18. MEDICAL CERTIFICATION</b>   |                               |   |                                  |   |  |   |  |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:   |                               |   |                                  |   |  | INTERVAL BETWEEN ONSET AND DEATH                              |  |
| Immediate cause (a) <u>Asphyxiation &amp; partial cremation</u><br>DUE TO<br>Antecedent cause(s) (b) <u>9/6.0</u><br>Diseases or conditions, if any, giving rise to the above cause DUE TO<br>stating underlying cause last (c)  |                               |   |                                  |   |  |   |  |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.  |                               |   |                                  |   |  |   |  |
| 19a. DATE OF OPERATION: <u>0</u>   |                               |   |                                  | 19b. MAJOR FINDING OF OPERATION:  |  |   |  |
| 20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>  |                               |   |                                  |   |  |   |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                               | 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>Home</u> )                              |                                  | 21c. (City or town) (County) (State) <u>Royal Oak Talbot 20 Md</u>  |  |   |  |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>11 12 55 PM</u>   |                               | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> |                                  | 21f. HOW DID INJURY OCCUR? <u>house burned down</u>   |  |   |  |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . |                               |   |                                  |   |  |   |  |
| SIGNATURE <u>Louis P. Mitty M.D. M.E.</u>  |                               |   |                                  | CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>11-17-55</u><br>DEPUTY MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAM. <input type="checkbox"/> M. D. |  |   |  |
| 23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>  |                               | DATE THEREOF <u>11/17/55</u>  |                                  | NAME OF CEMETERY OR CREMATORY <u>Royal Oak Cem</u>  |  | LOCATION (City, town, or county) (State) <u>Royal Oak Md.</u> |  |
| DATE REC'D BY LOCAL REG. <u>11-17-55</u>   |                               | REGISTRAR'S SIGNATURE <u>Mrs. Robert L. Selk</u>  |                                  | 24. FUNERAL DIRECTOR <u>James B. Ashwell, Eastern, Md.</u>  |  | ADDRESS   |  |

BUREAU V. S.

NOV 21 1955

RECEIVED



11250  
CERTIFICATE OF DEATH

Reg. Dist. No. 290...

|   |                               |  |   |   |   |  |                  |
|---|-------------------------------|--|---|---|---|--|------------------|
| 1. PLACE OF DEATH:  |                               |  |   | 2. USUAL RESIDENCE (HOME) OF DECEASED:  |   |  |                  |
| COUNTY <u>Talbot</u>  |                               | MARYLAND   |   | STATE <u>Md.</u>  |   | COUNTY <u>Cardowie</u>   |                  |
| CITY (If outside corporate limits, write RURAL OR and give nearest town)<br><u>40</u> TOWN <u>Easton</u>  |                               | LENGTH OF STAY (in this place)<br><u>3 hrs 15 min</u>  |   | CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR TOWN <u>Federalburg, Md.</u> <u>05X-2</u> |   |  |                  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br><u>80</u> <u>Memorial Hosp.</u>  |                               |  |   | STREET ADDRESS (If rural give location)   |   |  |                  |
| 3. NAME OF DECEASED: (First) (Middle) (Last)<br><u>Renee Victoria Towers</u>  |                               |  |   | 4. DATE (Month) (Day) (Year)<br>OF DEATH: <u>November 2, 1955</u>   |   |  |                  |
| 5. SEX:<br><u>M</u>   | 6. COLOR OR RACE:<br><u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):<br><u>single</u>   | 8. DATE OF BIRTH:<br><u>August 24, 1955</u> | 9. AGE last birthday<br>— yrs. <u>2 1/2</u>   | IF UNDER 1 YEAR<br>Months Days Hours Min. |  | IF UNDER 24 HRS. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):<br><u>Infant</u>   |                               | 10B. KIND OF BUSINESS OR INDUSTRY:<br><u>-</u>   |   | 11. BIRTHPLACE (State or foreign country):<br><u>Maryland</u>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA.</u>                      |                  |
| 13. FATHER'S NAME:<br><u>Bruce Towers</u>   |                               |  |   | 14. MOTHER'S MAIDEN NAME:<br><u>Shirley Covey</u>   |   |  |                  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)<br><u>Y</u>  |                               | 16. SOCIAL SECURITY NO.<br><u>No</u>   |   | 17. INFORMANT & ADDRESS:<br><u>My Bruce Towers (father)</u>   |   |  |                  |
| 18. MEDICAL CERTIFICATION   |                               |  |   | INTERVAL BETWEEN ONSET AND DEATH  |   |  |                  |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |                               |  |   |   |   |  |                  |
| 493X<br>IMMEDIATE CAUSE   |                               | (A) <u>Pneumonia</u>   |   | 1 day   |   |  |                  |
| ANTECEDENT CAUSE (S)  |                               | DUE TO   |   |   |   |  |                  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.   |                               | (B) <u>Feline Convulsions</u>  |   | 2 hrs.  |   |  |                  |
|   |                               | DUE TO   |   |   |   |  |                  |
|   |                               | (C)  |   |   |   |  |                  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.  |                               |  |   |   |   |  |                  |
| 19A. DATE OF OPERATION:<br><u>0</u>   |                               |  |   | 19B. MAJOR FINDINGS OF OPERATION  |   |  |                  |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                               |  |   |   |   |  |                  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.  |   | 21C. WHERE DID (City or town) (County) (State)  |   | INJURY OCCUR?  |                  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY<br>M.   |                               | 21E. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |   | 21F. HOW DID INJURY OCCUR?  |   |  |                  |
| 22. I hereby certify that I attended the deceased from <u>11</u> <u>2</u> , 19 <u>55</u> , to <u>11</u> <u>2</u> , 19 <u>55</u> ; that I last saw the deceased alive on <u>11</u> <u>2</u> , 19 <u>55</u> , and that death occurred at <u>1040 P</u> M, from the causes and on the date stated above. |                               |  |   |   |   |  |                  |
| SIGNATURE<br><u>John E. Bayliff</u>   |                               |  |   | ADDRESS<br><u>M. D. Barton Md</u>   |   | DATE SIGNED<br><u>11/4/55</u>                                    |                  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Burial</u>   |                               | DATE THEREOF<br><u>11/5/55</u>   |   | NAME OF CEMETERY OR CREMATORY<br><u>Jr. Order Cemetery</u>  |   | LOCATION (City, town, or county) (State)<br><u>Lecheester Md</u> |                  |
| DATE REC'D BY LOCAL REGISTRAR<br><u>11/3/55</u>   |                               | REGISTRAR'S SIGNATURE<br><u>N.H. Newell</u>  |   | 24. FUNERAL DIRECTOR<br><u>J.J. Frampton</u>  |   | ADDRESS<br><u>Ed. Son, Federalburg, Maryland</u>                 |                  |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



BUREAU V. S.

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A13C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11251

## CERTIFICATE OF DEATH

11271

Reg. Dist. No. 290

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| <b>1. PLACE OF DEATH</b>  |  |  |  | <b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>  |  |  |  |
| COUNTY <u>Talbot</u>  |  | MARYLAND   |  | STATE <u>Caroline</u>   |  | COUNTY <u>Caroline</u>   |  |
| CITY (If outside corporate limits, write RURAL OR end give nearest town)<br><u>40</u> TOWN <u>Easton</u>  |  | LENGTH OF STAY (In this place)<br><u>21</u> days   |  | CITY (If outside corporate limits, write RURAL end give nearest town)<br>TOWN <u>Denton</u>   |  | CITY <u>Maryland</u>   |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br><u>80</u> Memorial Hospital  |  |  |  | STREET ADDRESS (If rural give location)<br><u>05X-2</u>   |  |  |  |
| <b>3. NAME OF DECEASED</b> (Type or Print)<br>(First) (Middle) (Last)<br><u>Nannie M. Wright</u>  |  |  |  | <b>4. DATE OF DEATH</b> (Month) (Day) (Year)<br><u>November 24, 1955</u>  |  |  |  |
| <b>5. SEX</b><br><u>Female</u>  |  | <b>6. COLOR OR RACE</b><br><u>White</u>  |  | <b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>   |  | <b>8. DATE OF BIRTH</b><br><u>March 25, 1907</u>   |  |
| <b>9. AGE last birthday</b><br><u>48</u> yrs.   |  | <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>H.W.</u> |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b>  |  | <b>11. BIRTHPLACE</b> (State or foreign country)<br><u>Maryland</u>  |  |
| <b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>U.S.A.</u>  |  | <b>13. FATHER'S NAME</b><br><u>William Scott</u>   |  | <b>14. MOTHER'S MAIDEN NAME</b><br><u>unknown</u>   |  | <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)<br><u>9</u>                        |  |
| <b>16. SOCIAL SECURITY NO.</b>  |  | <b>17. INFORMANT &amp; ADDRESS</b><br><u>Mr. Thomas Wright</u>   |  | <b>18. MEDICAL CERTIFICATION</b>  |  | <b>19. INTERVAL BETWEEN ONSET AND DEATH</b>  |  |
| <b>1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>  |  | <b>(A) IMMEDIATE CAUSE</b><br><u>420.1 Cardiac failure due to</u>  |  | <b>(B) ANTECEDENT CAUSE(S) DUE TO</b><br><u>Coronary atherosclerotic heart disease</u>  |  | <b>(C) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b><br><u>Multiple pulmonary infarction</u> |  |
| <b>2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b><br><u>Diabetes mellitus</u> |  | <b>19a. DATE OF OPERATION</b><br><u>2</u>  |  | <b>19b. MAJOR FINDINGS OF OPERATION</b>   |  | <b>20. AUTOPSY?</b><br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| <b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>   |  | <b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>                                    |  | <b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>   |  | <b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>   |  |
| <b>21e. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | <b>21f. HOW DID INJURY OCCUR?</b>  |  | <b>22. I hereby certify that I attended the deceased from</b> <u>10/1</u> , 19 <u>55</u> , to <u>29/11</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>24/11</u> , 19 <u>55</u> , and that death occurred at <u>10</u> M, from the causes and on the date stated above. |  | <b>SIGNATURE</b><br><u>Thomas Wright</u> M.D. <u>Caroline</u> <u>Denton, Md.</u> <u>29/11/55</u>   |  |
| <b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b><br><u>Buried</u>  |  | <b>DATE THEREOF</b><br><u>Nov. 24, 1955</u>  |  | <b>NAME OF CEMETERY OR CREMATORY</b><br><u>Concord</u>  |  | <b>LOCATION (City, town, or county) (State)</b><br><u>Concord, Md.</u>   |  |
| <b>24. REC'D BY REGISTRAR</b><br><u>11-24-55</u>  |  | <b>REGISTRAR'S SIGNATURE</b><br><u>N. H. Neerius</u>   |  | <b>25. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>J. V. Moore</u>   |  | <b>ADDRESS</b><br><u>Denton, Md.</u>   |  |

BUREAU V. S.

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